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Report of the Commission of Inquiry into the **CONFIDENTIALITY OF HEALTH INFORMATION**

Commissioner
The Hon. Mr. Justice Horace Krever

VOLUME I

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Commissioner
The Hon. Mr. Justice Horace Krever
Counsel
Harvey T. Strosberg
Associate Counsel
Carene I. C. Smith

Royal Commission of Inquiry
into the
Confidentiality of Health Records
in Ontario

180 Dundas Street West
20th Floor
Toronto Ontario
M5G 1Z8
416/965-4003

September 30, 1980

The Honourable Dennis R. Timbrell,
Minister of Health for Ontario

Dear Mr. Minister:

I take pleasure in transmitting, with this letter,
the report of my inquiry into matters relating to the
confidentiality of health information in Ontario.

A handwritten signature in black ink, appearing to read "Horace Krever".

Horace Krever
Commissioner

Order-In-Council

O.C. 3566/77

Copy of an Order-in-Council approved by His Honour the Administrator of the Government of the Province of Ontario, dated the 21st day of December, A.D. 1977.

The Committee of Council have had under consideration the report of the Honourable the Minister of Health, wherein he states that,

WHEREAS, there has been considerable recent public discussion respecting the confidentiality of health and associated personal information.

The Honourable the Minister of Health therefore recommends that

1. pursuant to the provisions of The Public Inquiries Act, 1971, S.O. 1971, Chapter 49, the confidentiality of health and associated personal information, collected under legislation administered by the Minister of Health and any other relevant legislation administered by other Ministers of the Crown, be declared to be a matter of public concern, and that a Commission be issued appointing

THE HONOURABLE MR. JUSTICE HORACE KREVER, TORONTO

to conduct an Inquiry with the following terms of reference:

- 1) to review all legislation administered by the Minister of Health (for example, The Public Hospitals Act, The Health Disciplines Act, The Health Insurance Act and The Mental Health Act), together with any other relevant legislation administered by other Ministers, and any Regulations passed thereunder, to determine whether proper protection is given to the right of person who have received, or who may receive, health services, to preserve the confidentiality of information respecting them collected under that legislation;
- 2) to review the legality of the administrative processes under the above Acts; and
- 3) to report thereon to the Minister of Health with any recommendations for necessary amendments to the legislation and the Regulations passed thereunder;

2. All Government Ministries, boards, agencies and commissions be requested to assist the commission to the fullest extent in order that it may carry out its duties and functions;
3. The commission have the power and authority to engage counsel, expert technical advisors, investigators and other staff as it deems proper at rates of remuneration and reimbursement to be approved by the Management Board of Cabinet;
4. Part III of The Public Inquiries Act, 1971 be declared to apply to the said Inquiry and to the commission.

The Committee of Council concur in the recommendation of the Honourable the Minister of Health and advise that the same be acted on.

Certified,

Deputy Clerk, Executive Council.

Order-In-Council

O.C. 1129/78

Copy of an Order-in-Council approved by Her Honour the Lieutenant Governor, dated the 19th day of April, A.D. 1978.

The Committee of Council have had under consideration the report of the Honourable the Minister of Health, wherein he states that,

WHEREAS, pursuant to Order-in-Council numbered OC-3566/77 dated the 21st day of December, A.D. 1977, a Commission was issued appointing the Honourable Mr. Justice Horace Krever to conduct an Inquiry respecting confidentiality of health information;

AND WHEREAS questions have arisen as to the scope of the Inquiry, so that it is desirable that the terms of reference of the Commission be clarified;

The Honourable the Minister of Health therefore recommends that

1. the said Order-in-Council numbered OC-3566/77 be amended by striking out the terms of reference set out in Paragraph No. 1 thereof and substituting therefor the following:
 - 1) to review all legislation administered by the Minister of Health (for example, The Public Hospitals Act, The Health Disciplines Act, 1974, The Health Insurance Act, 1972 and The Mental Health Act), together with any other relevant legislation administered by other Ministers, and any Regulations passed thereunder, to determine whether proper protection is given to the rights of persons who have received, or who may receive, health services, to preserve the confidentiality of information respecting them collected under that legislation;
 - 2) to review the legality of the administrative processes under the above Acts;
 - 3) to investigate, inquire into and consider any misconduct, and any negligent or other improper activities, practices or conduct by any person, firm, corporation or organization in relation to the above Acts and Regulations and the administration thereof, including any non-compliance by any person, firm, corporation or organization with any of the above Acts and Regulations, and any activities, practices or other conduct by any person, firm, corporation or organization which coerced, induced, persuaded or otherwise prompted any such misconduct, negligence or other improper activity, practice or conduct, or which

constituted an attempt or an agreement to coerce, induce, persuade or otherwise prompt any such misconduct, negligence or other improper activity, practice or conduct; and

- 4) to report thereon to the Minister of Health with any recommendations for necessary amendments to the legislation and the Regulations passed thereunder.

The Committee of Council concur in the recommendation of the Honourable the Minister of Health and advise that the same be acted on.

Certified,

Deputy Clerk, Executive Council.

Preface

Although my inquiry was created by an Order-in-Council dated December 21, 1977, its terms of reference were not completely settled upon until the Order-in-Council of April 19, 1978. It was only then that the inquiry began its important public work. Our investigative hearings, which, for all practical purposes, began on April 20, 1978, continued, with only short interruptions to facilitate preparation, until April 17, 1979. Our policy hearings began on April 30, 1979, and ended on July 4, 1979. With the conclusion of the hearings, we turned to the arduous task of assimilating the evidence and oral submissions that had been given and made, the written briefs filed and the research undertaken. There were 141 days of public hearings during which 541 witnesses were heard. A further 20 witnesses testified during 6 days of in-camera hearings. The evidence consisted of 151 volumes of transcript and 807 exhibits, some of which were hundreds of pages in length. We received 253 briefs varying in size from a few pages to 2,000 pages. The writing of the report completed the task.

An undertaking of this magnitude, only partly reflected by these rather cold statistics, cannot be accomplished without a great deal of hard work on the part of a competent team. I was fortunate enough to be able to bring together a team of that calibre. Considering the scope of the inquiry and the size of the job to be done, we were not many but what we lacked in numbers my associates compensated for in ability, dedication and loyalty. It is impossible for me to find the appropriate words to express my appreciation for the comfort and assistance which they gave me without reservation. For the purpose of the record, however, some attempt must be made, inadequate as it clearly will be, to acknowledge the enormous contribution of those who have worked with me for the last two or more years.

If I made no other right decision in the course of this inquiry, my choice of counsel was inspired. Harvey T. Strosberg gave brilliant leadership to our investigation and his skill and intelligence, qualities with which he is plentifully endowed, were great assets to me and, it must be said, to the public, during our hearings and the writing of the report. He was more than ably assisted by my associate counsel, Carene I. C. Smith, whose service in the Legal Branch of the Ministry of Health I was able to interrupt though, understandably enough, not without some resistance from the Ministry. In addition to her important role as associate counsel, she assumed, to my great relief, responsibility for the supervision of our research. As if that were not enough, not long after the inquiry began, Miss Smith

was required to take on the duties of executive secretary or chief administrator, which she discharged as efficiently as she did her other responsibilities. Also ably assisting Mr. Strosberg was Steven B. Sharpe, who eventually became assistant counsel and who began his service with us as an articled student-at-law and ended as a fully qualified member of the Bar.

It may well be that the part of our task that was carried out best was our investigation, which turned out to be much more extensive than anyone could have predicted in the beginning. I am indebted to the Ontario Provincial Police for making available to me, for the purposes of our investigation, the excellent services of Detective Inspector Louis J. Pelissero, Detective Sergeant Joseph Vertolli and Corporal, now Detective Sergeant, Albert C. Ciampini. I also had the very considerable assistance of Gerald Richardson of Windsor, Ontario, who, at no small inconvenience to himself, completed our staff of investigators.

Our research was carried out under very difficult time and financial restraints. It could not have been done with persons of only average ability. Fortunately I did not have to settle for that. The members of our research group performed with rare dedication. I wish I could continue to have access to their services. They were Sandra Glasbeek, Barbara Casson Robin, Patricia Bregman, Chris Lewis, Robin Rowe, Harold Gershman, Juta Auksi, and Christine M. Jones. All of them generously performed other duties than research whenever help was required. I am also grateful for the assistance and advice from our outside consultants, Professor Sandra Rodgers-Magnet, Wayne Atkinson and Robert D. Humfrey, both of Peat, Marwick and Partners, H. Dominic Covvey, and Timothy G. Brown.

Two professional librarians, one succeeding the other, proved to us the benefit of library science but also unselfishly helped out with respect to our research and administrative needs. They were Elise Mecklinger and Patricia Rubin.

Special thanks are due Luciana Allan and Louise Larouche who were in succession, my secretaries, a far from easy responsibility. Miss Larouche typed almost every word of the report, most of it from drafts illegibly marked up by my scribbling. Other secretarial and stenographic services were dutifully and capably supplied by Diana Schwartz, Joanne Blazejewicz, Cathy Flanagan and Audrey Lucas. Carroll Brooks performed the difficult task of entering the report into the word processor, from which it went directly to the printer.

I received help and advice of inestimable value from many persons in unofficial and informal discussions during which, I am sure, I took liberties with, and excessive advantage of, an existing or new friendship. They are too many to mention. Three of them, however, must be named. They are Inger Hansen, the Privacy Commissioner of the Canadian Human Rights Commission, Professor Emeritus Wilbur F. Bowker, former Dean of the Faculty of Law of the University of Alberta and Professor Terence G. Ison, former Chairman of the Workmen's Compensation Board of British Columbia and now of Osgoode Hall Law School of York University.

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Introduction

This inquiry began as a modest study of provincial legislation and administrative processes under it. It began in response to a few allegations of invasions of privacy, particularly, but not exclusively, by police officers obtaining information which was supposed to be confidential from such custodians of that information as the Ontario Health Insurance Plan and hospitals. It was not long before it became a much more ambitious undertaking. The change occurred when our preliminary investigation revealed the true magnitude of the abuses that were taking place with respect to the confidentiality of health records in our society. As a result of a challenge, made at the outset of our public hearings, of my right to inquire into the conduct of persons not regulated by statute but who, it was alleged, caused or attempted to cause others to act contrary to the statutes governing their activities, a new order-in-council was made requiring me to investigate the conduct of all of those persons. The allegations and the conduct are dealt with in considerable detail in what follows.

Ontario is only one of many jurisdictions in the western world to express concern about the problems relating to the confidentiality of personal information such as health records. Indeed, interest seems to be universal. The rise of the information society has created anxiety about the use of information. The greater the capability of collecting, and the tendency to collect, personal information, the more alarm is expressed about the actual and potential misuse of what is collected. Internationally, there is a large and burgeoning literature on the subject. Studies and official inquiries have been undertaken in many jurisdictions. Privacy in this sensitive area has been and is in the course of being given protection by legislation, particularly in the United States. To my mind the two most important studies published to date are the Report of the Committee on Privacy, known as the Younger Report, which was presented to the Parliament of the United Kingdom in July, 1972, and the Report of the U.S. Privacy Protection Study Commission, entitled Personal Privacy in an Information Society, which was presented to the Congress in July, 1977. Nor has interest in this subject been confined to English-speaking nations. Europe has seen much study and

legislative activity. For example, on January 7, 1978, a new law was enacted in France to implement recommendations made in the 1975 Rapport de la Commission Informatique et Libertés (Committee on Data Processing and Liberties), a section of which was devoted to health information.

Because it is not humanly possible to reconcile all the conflicting interests that flourish in this field, some readers are bound to be disappointed with the solutions that are recommended. Most of the limitations to be found in the report are unintentional. There is, however, one that is deliberate. I do not discuss the law of evidence and thus the right of a physician to withhold from a court of competent jurisdiction information which comes to him or her from a patient. Nor do I deal with the litigation and judicial processes and thus, for example, the right of a defendant in a personal injury action to have a medical examination of the plaintiff or the adequacy of current discovery mechanisms in civil procedure. These matters have been considered in recent years and are being considered as these words are being written by the Law Reform Commission of Canada, the Ontario Law Reform Commission and the Civil Procedure Revision Committee, better known, perhaps, as the Williston Committee. I have had neither the time nor the resources to study these issues and, as a result, decline to discuss them. For the purpose of this report, and as a general rule, my concern ends where legal proceedings commence and the interests of disclosure for the purposes of litigation are brought to bear.

It may prove to be the case that if a particular problem of confidentiality is not the subject of discussion or treatment in this report the omission is not serious. It is highly likely that matters that presented difficulties before our hearings have now ceased to exist because of the very creation and proceedings of this inquiry. Our hearings, I am happy to say, received widespread coverage by the print and electronic media. The publicity created drew attention to the sources from which statutorily imposed confidentiality was under, or exposed to, attack. That resulted in a heightened awareness of the existence of the duty to protect confidentiality and of the nature of the danger to it. Indeed, so conscious of the subject did the public become that, in some sectors, an over-reaction occurred, with the consequence that even permissible and beneficial disclosures of health information, such as, for example, among administrators of public hospitals and to The Ontario Cancer Treatment and Research Foundation, came to an end. It is my opinion that, on the whole, even if there had been no report, in exposing the breaches of the various obligations of confidentiality, the inquiry would have served a good purpose. It

has certainly caused a re-examination of policies originally created to protect the privacy of information but which, with the passing years, have been executed in a less than satisfactory fashion. It will probably be agreed that self-regulation properly carried out is to be preferred over external regulation. In the light of the changed behaviour that one perceives to have resulted from our hearings, it may be the case that not all the recommendations made in this report require implementation. Because, however, the enhanced sensitivity to the threats to privacy I shall describe may be temporary, the recommendations, nevertheless, in my view, ought to be put into effect if only out of an abundance of caution. But, whatever the future may hold, the process brought about by the conduct of the inquiry has unquestionably been therapeutic.

Because of the interest of the public, as reflected by the treatment of the issue in the press, I have an obligation, I think, to say a few words at the outset about what some may regard as my principal recommendation. In my opinion, it is principal only in the context of the allegations that gave rise to the decision to create this inquiry. It is that no prosecutions be undertaken against those whose conduct is criticized in these pages. The recommendation was arrived at only after long and difficult consideration. I now give my reasons. First and foremost is my desire to focus attention on the need for future protection rather than on past behaviour. In the past, sensitivity about confidentiality, in Ontario, was not as high as it has recently become. This fact perhaps explains, though it does not justify, the many invasions of privacy and breaches of confidentiality that this inquiry has exposed. The period of insensitivity, as reflected by violations of confidentiality as a normal course of conduct, seems to have lasted from time immemorial compared with the duration of the awakening to the problems discussed in this report. Only relatively recently has society begun to articulate the interests requiring protection and the nature of those interests. Indeed one can safely say that the many statutes and regulations providing for protection of these interests have been ignored, not out of malice, but because persons in every walk of life were unaware of their existence. Not only have breaches been occurring for a long time but the disregard for privacy and for the interests protected by the concept of confidentiality has, as I have suggested, not been confined to a single group. It has been universal. In this pluralistic society of ours, every sector or group can make a claim for a need to know that is unique to it and that is seen by it to transcend in importance the interests of those who would have their privacy safeguarded. Thus the need for objectivity.

A decision to prosecute would, I believe, be seen by many objective members of society as being discriminatory in several respects. It is reasonably clear that those offenders whose activities came to our attention during the inquiry comprise only a fraction of those engaged in conduct of the same type. For example, the practices of certain lawyers are described in this report and those lawyers are identified. It is known, however, that the practices illustrated were not confined to the named lawyers but, on the contrary, extended throughout that part of the legal profession participating in personal injury litigation. No useful purpose, it seems to me, can be served by proceeding against scapegoats when the problem lies in the system itself and the solution in the reform of the system.

The kind of offence in respect of which a prosecution may now be undertaken is another aspect of discrimination. Much of the objectionable conduct encountered in the inquiry, if it amounts to the commission of offences at all, falls into the category of offences against or under provincial statutes which were, before the enactment of The Provincial Offences Act, 1979, S.O. 1979, chapter 4, known as offences punishable on summary conviction. For offences of this character the limitation period, that is, the period within which a prosecution must be commenced, was six months. The conduct occurred before the changed terminology and procedure under the new statute had been introduced. But even if, as a matter of law, The Provincial Offences Act, 1979 should be held to apply to prosecutions for acts committed so long ago, the result would be the same. Section 76(1) of the Act prohibits the commencement of proceedings in respect of provincial offences "after the expiration of any limitation period prescribed for the offence or, where no limitation period is prescribed, after six months after the date on which the offence was, or is alleged to have been, committed." On the other hand, some of the conduct of which I write probably amounts to the offence of conspiracy, an indictable offence created by the Criminal Code of Canada, R.S.C. 1970, chapter C-34, and an offence in respect of which there exists no limitation period. The consequence of this distinction is that, while, from a technical point of view, the prosecution of some offenders is possible, because of the short limitation period that governs, it is too late to prosecute the many.

There is yet another element of discrimination involved. Even for those whose conduct amounted to persuading or agreeing to persuade someone or some others to act in contravention of provincial legislation, there exists a distinction with important legal, though not moral, significance. It has been held by the Supreme Court of Canada, our highest judicial

authority, in the case of Wright, McDermott and Feeley v. The Queen, [1964] S.C.R. 192, that two or more persons who agree to obtain from a person information which it is that person's duty under provincial legislation not to divulge commit the criminal offence of conspiracy, by virtue of the language in section 423(2) of the Criminal Code. An attempt to obtain the same information on the part of one person, however, is not conspiracy. Since the essence of the offence of conspiracy lies in the agreement by two or more persons, the conduct of one person is logically excluded. That conduct may indeed make the actor party to the offence created by the provincial legislation, if there occurred prohibited disclosure, but he or she would then be committing not an indictable offence, but only an offence punishable on summary conviction, or, now, a provincial offence the limitation period for which, I repeat, is only six months.

I return to my principal point. Prosecutions would involve a diversion of energy from the main and important task at hand, namely that of the fostering of sensitivity in order to ensure that the infractions that were committed in the past are not repeated in the future. I am reasonably confident that the publicity surrounding our proceedings has had a demonstrable inhibiting effect on the ability of those inclined to do so to commit infractions of the kind we have seen. There is little evidence that abuses are continuing to occur today. I am not at all sure, however, that when the inquiry loses its high profile, there may not be a return to the bad old days unless, as I have said, the recommendations found in this report are implemented. Furthermore, to undertake prosecutions would smack of a search for scapegoats despite the fact that the climate in which the activities described in detail in these pages, and which have been carried on until recently, is something for which all of us should feel responsible. It is not altogether impossible, moreover, that a sense of injustice or unfairness will be generated because of the conviction on the part of many, if not most, of the offenders that, in doing whatever it was that might result in prosecution, they were, in their own sincerely held belief, engaged in activity that benefited someone or benefited society at large.

Recommendation:

1. *That no prosecutions be undertaken against those persons whose conduct is criticized in this report.*

A very large dimension of my study is the privacy aspect of the interests protected by the idea of confidentiality of health records. Privacy itself, as the literature shows, is a very

difficult and complex concept. There is a multiplicity of definitions. It is not important, for my purposes, to enter into an examination of the various definitions. A good many of them may conveniently be found in Appendix K of the Younger Report, referred to above. I acknowledge at once my indebtedness to the pioneering work of Professor Alan F. Westin in this field. His books, Privacy and Freedom and Computers, Health Records and Citizen Rights, have had a powerful influence not only on me but on all students of the subject. I commend both books to my readers but in my opinion the former is the definitive and, at the same time, the seminal work on the question. For the purposes of this report, I adopt one of Professor Westin's definitions of privacy in Privacy and Freedom. "Privacy," he wrote, "is the claim of individuals, groups or institutions to determine for themselves when, how and to what extent information about them is communicated to others." That definition, of course, has a direct relationship with confidentiality of health records. Implicit in the definition is the existence of an obligation on the part of those in possession of the information to respect the claim of those whom the information concerns. The need for privacy that all of us have as a dimension of human personality and dignity is effectively and graphically documented in Privacy and Freedom.

There are admittedly different approaches to privacy and confidentiality. One interesting analysis is that of Dean Jack R. London, of the Faculty of Law of the University of Manitoba. In his essay, "Privacy in the Medical Context", a chapter in the book Aspects of Privacy Law: Essays in Honour of John M. Sharp, forthcoming at the date of writing, and edited by Professor R. Dale Gibson, Dean London takes as his starting point the proposition that, in the absence of competing interests in the disclosure of information, free and uninhibited disclosure ought to be the rule. That is qualified by his second point which is that, more frequently than not, there are legitimate competing interests in the disclosure of information which require that a choice be made between the respective equities. The second proposition so qualifies the first that it is probable that, given the task of solving any problem relating to the confidentiality of health information, he and I would both select the same solution in most cases. Yet it is the remaining cases that trouble me. Often in these matters where one begins determines where one ends. I cannot accept the first proposition as a place of beginning although, in matters other than health, I might have no difficulty with it as a generalization. The sensitivity that so many members of our society have about health information--something I know intuitively as well as from anecdotal sources, conceding as I do, that I have no scientific or empirical evidence--means that there always exists

such an interest competing, and competing strongly, with the desirability of free and uninhibited disclosure that the proposition is robbed of its generality.

As I have suggested, my starting point is a presumption that our society values privacy for health information, creating a need for the observance of, or respect for, confidentiality. To put it another way, other things being equal, we do not favour free and uninhibited disclosure of everyone's health information. As with all generalizations, there are exceptions as, for example, the public's interest in the health of heads of state and political leaders. This is not to say, of course, that persons in that category would agree with the validity of the exception. We have recently seen the consequence of public disclosure of psychiatric counselling for a candidate for high public office in another nation. In any event, to the extent that there is any case to be made for these exceptions, they are just that--exceptions and not the rule. That conclusion is derived from the need we all have for privacy and the highly personal nature of the information that forms my subject matter.

But even if that were not my own view, I would certainly be driven to that basic philosophical position by the language of my terms of reference or mandate, that is, by the order-in-council governing my inquiry. I refer, first, to the recital in the first order-in-council, O.C. 3566/77, reproduced above, expressly stating that "the confidentiality of health and associated personal information, collected under legislation administered by the Minister of Health and any other relevant legislation administered by other Ministers of the Crown, be declared to be a matter of public concern." I draw the inference from those words that our society is concerned that there should be confidentiality for health and associated personal information collected under the authority of Ontario legislation. I find further support for that view in the purpose of my inquiry as contemplated by the same order-in-council, that is, "to review all legislation...to determine whether proper protection is given to the rights of persons who have received, or who may receive, health services, to preserve the confidentiality of information respecting them collected under that legislation."

Ontario society, I suspect, is not different from the larger North American society of which it is a part. In this connection, the introduction in the United States House of Representatives of the bill "To protect the privacy of medical information maintained by medical care facilities" (The Federal Privacy of Medical Information Act) on November 16, 1979, was

accompanied by the following pertinent remarks of Congressman Richardson Preyer of North Carolina, remarks which, generally speaking and with little modification, are as appropriate in Ontario as they are in his country:

Confidentiality has been an essential element of the medical care relationship ever since the dawn of medicine. In the fourth century B.C., the famous Greek physician Hippocrates recognized this in his oath for new doctors. The Hippocratic oath, which is still in use today, includes this clause:

Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

It is interesting to realize that even in ancient Greece, privacy was not viewed as an absolute value but one that must be balanced against other important values. The Hippocratic oath does not forbid all disclosures of medical information. It proscribes only the disclosure of information "which ought not to be spoken abroad." Deciding what information ought not to be spoken abroad remains a central issue in medical privacy.

When the doctor was the only person involved in the treatment of a patient, this oath was sufficient. A doctor is normally able to decide whether a disclosure of information is in the best interests of his patient. Today, however, there are many people besides doctors who assist in providing medical services and in paying for those services. Judgments about the release of sensitive medical information that were once made exclusively by doctors are now made by others who are not as well trained. Also, the complexity of modern society has made these decisions harder than they used to be. A disclosure of medical information that may not be in the best interests of a particular

patient may be beneficial to society at large.

For these difficult judgments, we can no longer rely on a one-sentence confidentiality oath. Doctors, hospitals, and others must be given additional guidance, and patients must be given additional protection. It is appropriate, therefore, that Congress enact legislation to define the proper uses of medical information.

In Ontario, the Hippocratic oath, although not irrelevant, is less important than the provision found in paragraph 21 of section 26 of Regulation 577/75, made under the authority of The Health Disciplines Act, 1974, S.O. 1974, chapter 47, and defining professional misconduct as it relates to members of the medical profession as "giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law." The more absolute nature of the language in this Regulation, as compared with that of the Hippocratic oath, does not affect the appropriateness of Congressman Preyer's analysis for our jurisdiction. Indeed, as the relevant portions of this report show, in many ways the Regulation may make some of the problems or the reconciliation of the conflicting interests more difficult.

I try to make clear elsewhere in the report that it is my opinion that an important aspect of the dimension of personality and human dignity, as reflected by the confidentiality concept, is that of access to one's own health information or, more accurately, health information about oneself. This has become a right by statute in various jurisdictions in the United States and Canada and has been proposed for legislation in the U.S. bill to which I have referred as well as in the recently released report of the Legal Task Force of the Committee on Mental Health Services in Ontario. Although more is to be said later on this very difficult and controversial subject, a few introductory remarks may not be out of order. Perhaps in no other field dealt with in this inquiry have such apparent anomalies arisen than in that of patients' access to information about themselves. Certainly no other issue has aroused such intense emotional reactions on the part of persons accustomed, by their own admission, to the paternalism of "protecting" patients from precise information. It is possible, experience demonstrates, to conceive of confidentiality as such an imperative that information must not be disclosed even to those persons to whom it directly relates. It, and not merely the physical forms in

or on which it is kept, is thought of as the private preserve or private property of the person collecting the information. On the other hand, the evidence uncovered during the inquiry shows that the very same information, that is, information concealed from the subjects, has been revealed to third parties, often rather indiscriminately, sometimes quite properly, and at other times without authority or justification. In fact, we have encountered situations in which incorrect information, which the subject has had no opportunity to have corrected because of the absence of a right of access, has, with unfortunate and harmful consequences, been transmitted to other persons.

As I have suggested, historically and even today in Ontario, this issue has been determined by the paternalism of those in possession of the records or other information. But that information was obtained from the patient or as a result of an examination of the patient with his or her consent. Only as much information as the professional person felt ought to be imparted to the patient was imparted. Why, many ask, should a patient who wants to know everything that has been recorded about him or her not be entitled to see what has been recorded? The acquirer of that information, after all, did not come upon it as part of a general education or as a result of academic research but, on the contrary, obtained it because of his or her physician-patient relationship with the individual to whom the data relate. Knowledge is power. Knowledge about another person, knowledge, that is, that the other person does not have, is, surely, power over that person. Does the therapeutic relationship truly require that a physician have power over his or her patient? Should a physician's judgment that I may be harmed by the information, or that I will be unable to handle the information, be decisive? If I, informed by my physician of the risks of reading my chart because of, for example, my lack of familiarity with the medical terminology used, choose to run that risk, should I be denied the opportunity? Indeed, is it really true, in this era of specialization and sub-specialization, that every member of the medical profession who sees a patient has such an intimate knowledge and a genuine understanding of that patient, psychologically and intellectually, no matter how brief the contact, that he or she can have the necessary knowledge to be able to judge whether the patient can cope with the information? Does that accurately describe, as I was told it does, the relationship to the patient of the consultant, the surgeon, the anaesthetist, the physician in the emergency department of a large urban general hospital, and the radiologist? And how can depriving a patient of the opportunity of reviewing his or her record be reconciled with respect for the dignity of every adult and mentally competent member of the community that our society wants to see respected? These are

but a few of the questions that the issue of access by the patient presents. A perfect reconciliation of the competing interests is beyond the power of fallible men and women to achieve. The reader will judge for himself or herself the acceptability of the answers offered in this report.

The term "health record" appears with considerable frequency throughout this report. It has no special or technical meaning. It is a generic expression, comprehending medical records and, generally, all information in any form about the health or physical or mental condition of the persons to whom it refers. In certain cases, for example in Regulation 729 under The Public Hospitals Act, R.S.O. 1970, chapter 378, other expressions are used. In the example given, the words are "medical record". That is so for the particular purpose at hand and it is not proposed that the purpose suffer interference for the sake of uniformity or in the interests of confidentiality. The point is simply that I interpret my mandate to include any form in which health information is kept. There is then, in my perception, no need to define "health record". My concern is the information which I have described and which I believe most persons regard as private and sensitive information.

As a matter of style, I try, throughout this report, to avoid referring to an inanimate Commission. Rather I use, as I think the sense makes appropriate, the first person, singular and plural, that is, "I" and "we". The plural is used wherever I want to refer to the collective nature of the work done during the inquiry, not to avoid my own responsibility for what was done and for what is said by seeking to dilute it. Similarly, "I" is used to make clear the responsibility which I must shoulder. If modesty were not put aside, a wrong impression might well be created.

Although every effort has been made to give consideration to the problems that have been drawn to our attention, because of the fact that concerns in this field are infinite in number, as I have said, some omissions will be discovered in the report. I believe that the more commonly occurring issues are addressed and I am confident that none has been ignored because of the difficulty that it presents. There is, however, one important matter of unfinished business. To postpone the completion of the report and its submission, in the expectation that that question can eventually be dealt with, would, in my opinion, delay the report too long. I refer to the subject of the appeal now pending in the Supreme Court of Canada. The Ontario Court of Appeal, in Re Inquiry into the Confidentiality of Health Records in Ontario (1979), 24 O.R. (2d) 545, 98 D.L.R. (3d) 704, 47 C.C.C. (2d) 465, in response to questions put by me in a case

stated originally in the Divisional Court, has held that the Royal Canadian Mounted Police have no right to withhold from me in this inquiry the names of physicians and hospital employees who, without patient consent, gave them health information about their patients, contrary to the relevant provisions of Regulation 577/75 under The Health Disciplines Act, 1974 and Regulation 729 under The Public Hospitals Act. As appears in the body of the report, our own investigation resulted in the identification of a number of physicians and hospital employees who had behaved in the same way, but an additional number who are known to us to have given information in the same circumstances cannot be identified without the assistance of the members of the RCMP who sought and received the information. The result is that, as to these physicians and hospital employees, I have been unable to complete my mandate by investigating the nature of the information disclosed and the explanation for the contraventions which took place. The decision of the Court of Appeal that I am entitled to the information is being challenged by the RCMP and the Solicitor General of Canada in the pending appeal before the Supreme Court of Canada. That appeal, with relation to the time of writing, cannot be heard and disposed of for some time. If the appeal is heard and allowed, the result will be that that part of the inquiry cannot be completed. If, on the other hand, the appeal is dismissed and the judgment of the Court of Appeal affirmed, there will still be some questions to ask and to be answered. It is my belief that it is preferable to keep that matter outstanding than to postpone the transmittal of this report.

CHAPTER 2

Recommendations

CHAPTER 1: INTRODUCTION

1. That no prosecutions be undertaken against those persons whose conduct is criticized in this report.

CHAPTER 4: THE PHYSICIAN-CLIENT RELATIONSHIP

2. That all public hospitals require their employees and persons with practising privileges to wear an identification badge containing the wearer's name, position and photograph.

CHAPTER 5: CENTURION INVESTIGATION LIMITED

3. That no corporation or individual licensed under The Private Investigators and Security Guards Act be permitted to own an interest of any kind in an insurance adjusting firm or to carry on business as an insurance adjuster.

CHAPTER 7: EQUIFAX SERVICES LIMITED

4. That The Private Investigators and Security Guards Act require that a majority of the issued and allotted voting shares of a corporation licensed under the Act be beneficially owned by persons ordinarily resident in Canada.

CHAPTER 9: ALBERT GEORGE OXLADE AND GRIFFIN INVESTIGATION AGENCY

5. That in order to prevent an insurer who obtains health information under Schedule "E" of The Insurance Act from voluntarily disclosing it to a person or corporation adverse in interest to the insured, the Act impose an obligation of confidentiality upon

every insurer in respect of that information, provided, however, that if the Schedule "E" insurer is also the third party insurer it may use the information for the purposes of any claim against the insurer or its insured.

6. That private investigators licensed under The Private Investigators and Security Guards Act be prohibited from representing that they are insurance adjusters.

CHAPTER 10: W.A. KING LTD. AND C.C.R.

7. That the subrogation department of OHIP refuse to provide any information to private investigators. The department should deal only with licensed insurance adjusters, insurance companies, or solicitors in attempts to settle its subrogated claims.
8. That no individual, partnership or corporation carrying on business as an insurance adjuster be permitted to carry on business as a private investigator or own an interest of any kind in a corporation licensed as a private investigator under The Private Investigators and Security Guards Act.

CHAPTER 11: CORTLAW SERVICES LIMITED

9. That The Private Investigators and Security Guards Act prohibit the use by a licensee of any business name suggesting a connection or association with the law or the legal system.

CHAPTER 12: JOLIE & TODD INVESTIGATIONS

10. That The Drugless Practitioners Act be amended to impose an obligation of confidentiality with respect to the health information of patients.

CHAPTER 14: THE AUTOMOBILE CASUALTY AND LIABILITY INSURANCE INDUSTRY IN RETROSPECT

11. That wherever a duty of confidentiality with respect to health information is found in a regulation, it be transferred therefrom to the parent statute.

12. That in connection with third party liability claims, insurance companies, their agents and representatives be prohibited from communicating with physicians, hospitals or other persons under a duty to keep health information confidential unless the patients concerned have expressly authorized the communication.
13. That a statutory right be created permitting a patient whose health information has been disclosed without his or her authorization, to maintain a civil action for the greater of his or her actual damages or \$10,000.00 against:
 - (a) any health-care provider or other person under an obligation to keep health information about the patient confidential, who unjustifiably discloses his or her health information to a third person; and
 - (b) any person who induced anyone under an obligation to keep health information about a patient confidential, unjustifiably to disclose his or her health information.

CHAPTER 16: THE POLICE AND LAW ENFORCEMENT

14. That all necessary steps be taken to separate accommodation for the police from OHIP facilities.
15. (1) That the district manager of OHIP or a person designated by him or her in writing at a district or satellite office, and only such a person, be permitted to disclose enrolment information to the police.

(2) That the person so designated must ensure that the person seeking the enrolment information is, in fact, a police officer by requiring the police officer to attend in person or by the use of a call-back system.

(3) That a log be maintained at every district and satellite office to record the date of the request, the name of the person seeking the information, his or her police force, his or her badge number, the subscriber or person about whom

information was requested, and why the information was sought and given.

16. That OHIP be required to report yearly to the Minister of Health particulars of the number of requests received from the police, in general terms, the circumstances under which information was sought and the number of occasions on which enrolment information was given. The Minister of Health should make full disclosure of this OHIP report to the public.
17. That no employee of OHIP be permitted to release health information to any police force without a search warrant. The district manager of OHIP or a person designated by him or her in writing at a district or satellite office should, however, be permitted to answer, yes or no, to the question of any police officer whether OHIP has specific health information about a named person.
18.
 - (1) That the director of the Insurance Claims Branch of OHIP or a person designated by him or her in writing be permitted to disclose, in writing, enrolment information to the Department of Employment and Immigration, in response to a written request setting out the purpose for which the enrolment information is required.
 - (2) That OHIP keep a copy of every written request and reply in a central location.
19. That OHIP be required to report yearly to the Minister of Health particulars of the number of requests received from the Department of Employment and Immigration, the purpose for which the enrolment information was required, the number of requests and the number of occasions on which enrolment information was given. The Minister of Health should make this OHIP report public.
20. That hospitals, health-care facilities and individual health-care providers be permitted to disclose information to the police about a patient who the police reasonably believe is dead, for the purposes of aiding in the identification of a body.
21. That no legislation be enacted that would require hospitals or health-care facilities, the employees of

hospitals or health-care facilities, physicians or other health-care workers to report to the police gunshot wounds, stab wounds or any other injuries indicating the commission of a crime or a statement by a patient of any intention to commit a crime.

22. That the relevant regulations under The Health Disciplines Act, 1974 be amended to provide that, where a health-care provider whose profession falls within The Health Disciplines Act, 1974 and who is not working in a health-care facility or under the direction of a physician has reasonable cause to believe that a patient is in such mental or emotional condition as to be dangerous to himself or the person of another or others and that disclosure of information about the patient is necessary to prevent the threatened danger, the health-care provider may disclose such information to the police or others without the consent of the patient. Disclosure made under that reasonable belief shall not amount to professional misconduct.
23. That legislation be enacted to provide that, when a senior official of a hospital or health-care facility has reasonable cause to believe that a patient is in such mental or emotional condition as to be dangerous to himself or the person of another or others and that disclosure of information about the condition of the patient is necessary to prevent threatened danger, he or she, specially designated by the board of the hospital or health-care facility for the purpose, may disclose that information without the consent of the patient.
24. That when a senior official of a hospital or health-care facility or a physician believes, on reasonable grounds, that a patient has been a victim or the perpetrator of a crime, he or she may so inform the police without the patient's authorization.
25. (1) That administrators of hospitals and health-care facilities, or senior employees designated by them in writing, be the only persons permitted to disclose health information from the records of their respective facilities, or in the possession of employees of those facilities, to the police without patient authorization.

(2) That, before disclosure is made, steps be taken to ensure that the person seeking the information is, in fact, a police officer by requiring the police officer to attend personally at the hospital or health-care facility, or by using a call-back system.

(3) That a log be maintained at every hospital and health-care facility, to record the date of the request, the name of the inquirer, his or her police force, his or her badge number, the patient about whom the information was sought, the purpose for which the information was sought, whether information was provided or denied and the substance of the information provided.

26. That every hospital and health-care facility in Ontario be required to report yearly to the Minister of Health the number of police attendances for confidential information, in general terms, the circumstances in which the information was sought, the number of occasions on which information was given and the number of occasions on which it was refused. The Minister of Health should make these statistics public.

27. That hospitals, health-care facilities and individual health-care providers not be obliged to record in their patients' records the fact of any contact with the police or the substance of any information given to the police in cases in which patient information has been given to the police without the patients' authorization.

28. That, on receipt of a subpoena or any other process requiring an individual health-care provider, or the custodian of a medical record in a hospital or health-care facility, to attend to give evidence, he or she not disclose health information, without the patient's authorization, in advance of, or in preparation for, his or her attendance as a witness in the proceeding.

29. That the responsibility for the regulation of the private investigation industry remain with the Registration Branch of the Ontario Provincial Police.

30. That the Ontario Provincial Police allocate sufficient manpower and expertise to regulate the private investigation industry properly.
31. That The Private Investigators and Security Guards Act be amended to allow the Registration Branch to inspect investigators' records and reports even in the absence of a complaint.
32. That the members of the Registration Branch be under an obligation of confidentiality with respect to the contents of the investigators' files inspected, and be required to refrain from disclosing any information acquired during inspection of investigators' files to officers in other branches of the OPP or officers of any other force, and to use this information only for the purposes of registration hearings or for the prosecution of any breaches of the law.
33. That private investigators have an obligation to maintain books, records and copies of all reports. This obligation should not apply in situations in which investigators are retained by lawyers acting for the defence in criminal or quasi-criminal matters. In those circumstances, the defence lawyer involved should be permitted to take custody of all notes, records and reports relating to the case.
34. That in the event that the Legal Branch of the Ministry of Health desires another legal opinion with respect to the validity of a search warrant or any other process directed to provincial psychiatric facilities, the opinion be sought from a non-government lawyer rather than from the Crown Office.
35. That all hospitals and health-care facilities keep a record of all search warrants executed against them.

CHAPTER 18: COMPUTER-SUPPORTED SYSTEMS IN HEALTH: THE THREAT TO PRIVACY

36. That, before the establishment of any medical data base, the person or agency who will be responsible for protecting the confidentiality of the information carry out the following requirements:

- (a) State the purpose for which the data are being collected, indicate the class or classes of patients in respect of whom it is being collected, and list all data items to be included.
- (b) Set out the quality control procedures which will ensure that data are accurately collected and properly linked to the correct patient.
- (c) Set out all physical and software security procedures to protect the data from unauthorized access or destruction. Security should be required to meet a standard corresponding to the sensitivity of the information stored.
- (d) Designate the person directly responsible for protecting the confidentiality of the information, to whom violations of any individual's privacy are to be reported.
- (e) Show that all persons who have access to data have been informed of their responsibilities for confidentiality and that a system exists for protecting the confidentiality of the data.
- (f) Specify to whom and where such data may be transmitted, circulated or otherwise given.
- (g) Define the special and ultra-secure procedures associated with personal identification data and the methods by which it is guaranteed to be kept separate from other data.

37. That the names of medical data bases and the files they include, an itemization of the contents of the files, and the names of those responsible for their maintenance and safekeeping be centrally registered in a data base, public access to which is available.

38. That a set of minimum guidelines be established for the security of specific kinds of medical data base systems. (There may be several classes of systems, such as data bases collected and kept within an institution, multi-institutional data bases, and province-wide or nation-wide data bases.) Data bases may also be classified according to the sensitivity of their data, the size of the data base and the potential for linkage of multiple data sets of different types. The minimum guidelines should

specify the minimum physical security for access to the system and its terminals, the kinds of minimum software security implemented in the data base software, and the methods of backup and duplicate logging in order to protect the data base from deliberate or inadvertent destruction.

39. That any data about a given patient kept on a medical data base used in patient care be available for review by the patient on request. There should be a mechanism for correcting data or at least indicating that the patient and the receiver of data differ about a given item.
40. That procedures for the purging of data, the destruction of media and the keeping of copies be established both for long-term systems and for systems which exist transiently in support of limited-term projects.
41. That an ombudsman of medical data bases or the equivalent be appointed to act as an overseer ensuring that the rights of the individuals are protected, that grievances can be redressed, that violations can be detected and that the guidelines are kept up-to-date.
42. That there be:
 - (a) a regular review of all systems and a constant updating of the list of responsible personnel and the contents of data files;
 - (b) a means of ensuring that problems are corrected and that violations of patient privacy are addressed;
 - (c) a mechanism for the updating of procedures with new technologies; and
 - (d) a means of publishing documented violations, important potential violations, or suspected violations of computer system security whenever they are detected.

CHAPTER 19: THE HOSPITAL MEDICAL RECORDS INSTITUTE

43. That The Public Hospitals Act or a regulation made thereunder, or any successor legislation to the Act that may be passed, expressly authorize the practice of releasing patient information to the Hospital Medical Records Institute for data processing.
44. That printouts received by hospitals from the Hospital Medical Records Institute containing individually identifiable material be subject to the same confidentiality, security and access provisions to which hospital medical records are subject. In the case of purely statistical reports, less restrictive access may be justifiable, so long as information about individuals cannot be identified even indirectly.

CHAPTER 21: HOSPITALS AND OTHER HEALTH-CARE INSTITUTIONS

45. That all facilities or institutions legally empowered to provide health-care services and maintaining patient records be regulated by the same or similar provisions governing the confidentiality of patient information.
46. That legislation protecting patient information in hospitals and health-care facilities be made applicable to any knowledge or information pertaining to the health, care, assessment, examination or treatment of the patient, unless the knowledge or information is in a non-identifiable form.
47. That legislation governing the confidential information maintained by hospitals and health-care facilities require each hospital or health-care facility to develop its own policies and procedures, compatible with the legislation, to regulate the collection, retention, storage, security, access, release and destruction of all confidential patient information.
48. That legislation require the administrator of every hospital to appoint or designate an information manager, to be responsible for implementing and co-ordinating the policies and procedures for management of all patient information in the hospital. In the absence of such an appointment, the responsibilities

and duties of information manager should reside in the administrator.

49. That hospitals and health-care facilities
 - (a) inform all employees of their individual responsibility to protect the confidentiality of patient information;
 - (b) instruct all employees in the institution's written confidentiality policies; and
 - (c) inform all employees of the penalties for the violation of these policies.
50. That legislation governing hospitals and health-care facilities impose on all employees and other persons working therein, the duty not to release patient information without the consent of the patient except when required or permitted by law.
51. That legislation provide that a hospital or health-care facility may collect only information required for the care, assessment, examination or treatment of the patient unless he or she consents to the collection of information for other purposes.
52. That the legislation and regulations requiring hospitals and health-care facilities to retain patient-identifiable health-related documents and materials be reviewed and, where necessary, amended, to ensure that patient information is retained in an appropriate manner and for a period which is consistent with minimum medical and legal requirements.
53. That all hospitals and health-care facilities maintain their confidential patient information in designated areas which are physically secure, under the immediate control of designated persons and not accessible to or available for inspection by unauthorized persons.
54. That hospitals and health-care facilities
 - (a) provide for destruction procedures for all types of patient information which will render the information completely and permanently unidentifiable;

- (b) safeguard the confidentiality of the information during the entire destruction process, including the period it is awaiting destruction and while being transported to the site of destruction;
- (c) destroy confidential information according to a written retention schedule consistent with the terms of legislation; and
- (d) record the particulars of the destruction in a log or by statutory declaration where required by law.

55. That the legislation governing the confidential information maintained by hospitals and health-care facilities designate all persons or groups of persons who may receive or inspect confidential information, as well as the purposes for which their receipt of information is authorized, prohibiting disclosure of or access to information under all other circumstances unless the patient has consented to the disclosure or it is made pursuant to a search warrant, subpoena or order of a court of competent jurisdiction.

56. That legislation require hospitals and health-care facilities, when they exercise a discretion to disclose, to limit their disclosure of confidential patient information to the amount and type of information necessary to accomplish the purpose for which the disclosure is authorized.

57. That hospitals and health-care facilities permit the disclosure of information only to authorized persons whose identity has been properly verified.

58. That legislation governing hospitals and health-care facilities require these establishments to record the particulars of every request for confidential patient information, except for those made by hospital staff members for routine hospital purposes. The access to and disclosure of this information must be logged both in a central registry and on the patient's record itself, the registry being retained separately for an adequate period of time.

59. That, where confidential patient information maintained by hospitals and health-care facilities is disclosed without the consent of the patient under

any of the provisions in the legislation allowing for such disclosure, legislation require that the confidential patient information so disclosed not be further disclosed in identifiable form unless it is required by law, or unless the information is required to relieve an emergency situation affecting the health or safety of any person.

60. That legislation permit access to confidential information within hospitals and health-care facilities for the purposes of patient assessment or treatment, internal administration, audit and quality control, research, statistical compilation, and education but only to those staff members whose access has been specifically approved by the respective boards and formally designated in their by-laws.
61. That where a claim is made or an action is brought against a hospital by a patient or former patient in respect of the care given to the patient, the hospital board, through the administrator, be permitted to disclose the contents of that patient's medical record to the hospital's liability insurer and solicitors to enable them to ascertain the circumstances giving rise to the claim or action and, where appropriate, defend the hospital's position.
62. That a hospital board's right to such statistical and non-identifiable information as it requires in order properly to discharge its obligation to govern and manage its hospital be given express statutory recognition.
63. That in exceptional cases, where it is essential for the discharge of their duties, members of hospital boards be permitted to have access to patients' medical records. Requests for access should be made to the administrator, who must obtain the approval of the board before permitting the access.
64. That the obligation of confidentiality binding on hospital employees be extended to members of hospital boards.
65. That legislation permit the hospital or health-care facility to release patient information to an outside service organization without patient authorization, provided that the agreement between the parties provides for regulation of access to, release, handling,

transmittal, security and destruction of identifiable patient information.

66. That the legislation governing hospitals and health-care facilities permit the transfer of patient information to a designated receiver in another hospital or health-care facility to which a patient is being directly transferred without the written consent of the patient, provided that the patient (or the patient's representative) has been notified of the intended transmittal before it occurs in order that he or she may have the option to prohibit the disclosure. If the urgency of the situation or the patient's condition prevents this notification, this fact must be duly noted and the patient informed of the transfer of information as soon as possible after the fact.

67. That, where the transfer of a patient is not involved, a hospital or health-care facility be permitted to release confidential patient information to another health facility without the consent of the patient if there is a threat to the patient's life, health or safety. In any other case the patient's authorization must first be obtained.

68. That the legislation permit hospitals and health-care facilities to transmit patient information, without the written consent of the patient, to the physician who referred the patient to the hospital or the physician to whom the patient is being referred by the attending physician for further care, provided that the patient (or the patient's representative) has been notified of the intended transmittal before it occurs in order that he or she may have the option to prohibit the disclosure. If the urgency of the situation or the patient's condition prevents this notification, this fact must be duly noted and the patient informed of the disclosure of information as soon as possible after the fact.

69. That, where a referral by the attending physician to another physician is not involved, legislation permit a hospital or health-care facility to release confidential patient information to the patient's physician without the consent of the patient if there is a threat to his or her life, health, or safety. In any other case, the written authorization of the patient must first be obtained.

70. That legislation permit a hospital or health-care facility to reveal the presence of a patient, his or her location and his or her general condition to any person who inquires, but only if the patient (or the patient's representative) has not objected, in writing, to this disclosure. The hospital or health-care facility shall not reveal specific information about the patient's condition or treatment unless required or permitted by law.
71. That legislation governing confidential information maintained by hospitals and health-care facilities permit the disclosure of information concerning a patient who is confined in a correctional institution and who has been hospitalized, to the superintendent, director or medical officer of the patient's institution, for the purpose of maintaining the health of the patient, provided that the patient is notified of the disclosure.
72. That legislation governing the confidential patient information in hospitals and health-care facilities authorize the examination and receipt of any patient information by a coroner or his authorized representatives in accordance with the provisions of The Coroners Act, 1972.
73. That the reporting of confidential information to designated authorities under mandatory reporting requirements be reflected in legislation governing the confidentiality of patient information maintained by hospitals and health-care facilities by identifying every reporting requirement.
74. That legislation governing hospitals and health-care facilities permit the appropriate representative appointed by any college governed by The Health Disciplines Act, 1974 the same right to examine and receive confidential patient information as is now found in section 48(4) of Regulation 729 with respect to The College of Physicians and Surgeons of Ontario.
75. That legislation providing for the collection, audit or inspection of confidential patient-identifiable information maintained by hospitals and health-care facilities by government recipients require that every category of government recipient conduct a

review on a periodic basis and report to the Deputy Minister of Health or his designate with respect to:

- (a) the purpose and objective in obtaining this information;
- (b) the method used to achieve the purpose, to determine if it is the least intrusive possible. (Methods of achieving the purpose without using patient-identifiable information should be sought. Consideration should be given to employing persons with medically-oriented training or qualifications in positions with a high frequency of exposure to sensitive medical information);
- (c) the quantity, quality and use of the information obtained, to determine if practices are consistent with the stated requirements; and
- (d) the procedures in place to safeguard the confidentiality of the information and to provide for its prompt destruction, including a retention schedule and logging and destruction procedures.

76. That legislation governing the confidential information maintained by hospitals and health-care facilities permit the disclosure of health information to prescribed government recipients authorized to collect, audit or inspect confidential information under provincial legislation.

77. That access to confidential patient information by the official representatives of accreditation surveyors for the purpose of granting or reviewing accreditation be permitted under legislation governing hospitals.

78. That the Government of Ontario request the Federal Government to adopt for its health-care facilities operating in Ontario the same minimum requirements for protecting the confidentiality of patients' health information as is found in Ontario provincial legislation.

CHAPTER 22: INDIVIDUAL HEALTH-CARE PROVIDERS

79. That legislation providing for the disclosure of health information for the purposes of audit or professional monitoring require that any person who obtains information for these purposes,

- (a) remove or destroy information that enables patients to be identified where identity is not relevant or necessary to the investigation or, if identifiable information is necessary, at the earliest opportunity after the completion of the investigation;
- (b) be prohibited from further use or disclosure of identifiable health information unless required by law or unless the information is required to relieve an emergency situation affecting the health or safety of any person;
- (c) be required, on a periodic basis, to provide a report to the Deputy Minister of Health or his designate setting out,
 - (i) the purpose of the audit or monitoring;
 - (ii) how the information required is being used, to determine if practices are consistent with the purpose as stated and the legislative requirements for the audit or monitoring;
 - (iii) the method used to achieve the purpose, to determine if it is the least intrusive possible with respect to the use of identifiable patient information; and
 - (iv) the procedures in place to safeguard the physical security of identifiable patient information, including logging procedures, destruction procedures and a retention schedule.

80. That the definition of professional misconduct applicable to all health-care providers whose professions fall within The Health Disciplines Act, 1974 reflect the basic requirement that patient information, including information with respect to professional services performed, should be kept confidential, and

not disclosed to any other person without the consent of the patient, unless required by law, or unless there is a threat to the life or safety of the patient or another.

81. That agreements between the Ministry of Health and Health Service Organizations provide:
 - (a) that ownership and control of patients' medical records by the board of the Health Service Organization carry with it an obligation on the part of the board to maintain the confidentiality of the medical records;
 - (b) that there be no access by the Health Service Organization's board or its members and the staff, other than the professional staff, to the patients' medical records without the consent of the patients; and
 - (c) that the board of the Health Service Organization not permit the disclosure of medical information from the medical records of a patient without the consent of the patient unless required by law or except where there exists a threat to the life or safety of the patient or another.

CHAPTER 23: ACCESS TO ONE'S OWN HEALTH INFORMATION

82. That legislation be enacted to express the general rule that an individual has a right to inspect and receive copies of any health information, of which he or she is the subject, kept by a health-care provider.
83. That a Health Commissioner, a well-respected, non-member of the health professions, be appointed, whose responsibilities would include receiving applications by health-care providers for an exemption from the obligation to disclose information to a requesting subject, receiving applications by an individual for corrections to his or her health information, making a decision on the applications, and informing the health-care providers and the subjects of the decision.
84. That when, in the opinion of the health-care provider, disclosure of the information is likely to

have a detrimental effect on the physical or mental health of the requesting individual or other person, an application may be made by the health-care provider to the Health Commissioner for an exemption from the obligation to disclose that information. The decision of the Health Commissioner should be subject to an appeal to the County or Supreme Court.

85. That, after inspecting or receiving the health information, an individual have a right to request that the information be corrected. The health-care provider shall make the correction as requested or inform the individual of the reasons for the refusal. In the event of a refusal, the individual may apply to the Health Commissioner for review of the refusal. The decision of the Health Commissioner should be subject to an appeal to the County or Supreme Court.

CHAPTER 24: PSYCHIATRIC RECORDS AND THE ADVISORY REVIEW BOARD

86. That the notes made by the psychiatrist members of the Advisory Review Board and any other members who, before the review, interview the patient, intended for use in the deliberations conducted in the executive session of the Board, be protected from disclosure to the patient or his or her counsel unless the Board, in its discretion, decides otherwise.
87. That The Mental Health Act be amended to make it clear that the Advisory Review Board, for the purposes of its review of the cases of patients detained under the authority of a Lieutenant Governor's warrant, has the right to inspect any information in the hands of the psychiatric facilities in which the patients are detained, including the patients' clinical records.
88. That The Mental Health Act be amended to express the general rule that, for the purpose of a hearing before the Advisory Review Board, the patient or his or her counsel has a right to inspect the patient's clinical record. If the administrator of the psychiatric facility to which the patient is related is of the opinion that, in the interest of the patient's treatment, recovery, health or safety, or the health or safety of another person, access to the clinical record ought to be denied, that issue should be

decided by the Chairman of the Advisory Review Board, whose decision should be subject to review by the Divisional Court or a judge of that Court.

89. That the recommendations of the Advisory Review Board and the subsequent decisions of the Cabinet be treated confidentially and not be made available for public access.

CHAPTER 25: CONSENT TO DISCLOSURE

90. That legislation permitting disclosure of health information pursuant to a patient's authorization require that the authorization:

- (a) be in writing and contain the original signature of the subject of the health information as well as the original signature of a witness;
- (b) be dated;
- (c) specify the name or description of the recipient of the information;
- (d) specify the name or description of the person or institution intended to release the information;
- (e) include a description of the information to be disclosed;
- (f) specify the purpose for which the information is requested;
- (g) include an expiration date or time limit for the validity of the authorization; and
- (h) specify that the individual may rescind or amend the authorization in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.

91. That a standard form of authorization for disclosure of health information, in accordance with conditions (a) to (h) of Recommendation 90, apply to all health information maintained by health-care providers, including psychiatric facilities.

92. That when, in the opinion of the health-care provider, the physical or mental condition of a patient prevents him or her from having the ability to understand the subject matter in respect of which consent is requested and from being able to appreciate the consequences of giving or withholding consent, authorization for the disclosure of the information may be given by the patient's nearest next of kin.
93. That the parent or legal guardian of a patient under the age of 16 years may authorize the disclosure of his or her health information to a third person.

CHAPTER 26: RESEARCH

94. That a health-care facility be permitted to disclose identifiable health information to a qualified researcher for the purposes of a research project without the consent of the subjects involved, provided that approval has been granted by an appropriate human experimentation committee whose members must not be confined to the principal investigator's discipline and must include one or more representatives of the public, and provided also that that human experimentation committee has been satisfied that the principal investigator has met the following criteria:
 - (a) the identifiable information sought is indispensable for the purpose of the research project;
 - (b) the importance of the research project, in the opinion of the committee, justifies the breach of the subject's privacy; and
 - (c) the principal investigator undertakes
 - (i) that he or she will provide adequate physical security for the information;
 - (ii) that he or she will remove or destroy information identifying the subjects at the earliest opportunity compatible with the requirements of the research project; and
 - (iii) that he or she will not further disclose the identifiable health information except

to persons who must have access to it for the purpose of the project, or in an emergency situation in which there is a risk to the life or safety of a subject or another person, or when required to do so by law.

CHAPTER 27: THE UNIQUE PERSONAL HEALTH IDENTIFIER

95. (1) That, if a unique health identifier is adopted by the government, its adoption be implemented only in conjunction with the establishment of a central data protection agency responsible for authorizing the use of the unique health identifier and for approving data linkage between files, one or more of which use the unique health identifier.

(2) That the agency be responsible to the Legislature. All proceedings of the agency should be open to the public.

(3) That, in deciding whether a data bank should be authorized to use the unique identifier, the following questions be considered:
 - (a) whether the data bank falls within the definition of health information promulgated by the agency; and
 - (b) whether adequate plans have been made to ensure the physical security and confidentiality of the data.

Both the definition of health information and the minimum security guidelines should be published.

96. That, if a unique personal health identifier is adopted, it should not be the social insurance number.

CHAPTER 28: MANDATORY REPORTING OF HEALTH INFORMATION

97. That all persons about whom a mandatory report is made be informed, by the recipient, of the fact that a report has been filed and of the nature of the content of the report. The name of the person filing

the report and other identifying characteristics of the information may be deleted if the report was made in confidence.

98. That legislation requiring reporting by health-care providers not be enacted unless the following circumstances exist:
 - (a) the information, in an identifiable form, is necessary to protect the health and well-being of the public or a substantial number of members of the public;
 - (b) there is no other method by which the purpose could be accomplished; and
 - (c) the benefit to the public or members of the public sought to be protected outweighs the risk to the subjects of the reports from the invasion of their privacy.
99. That the Deputy Minister of Health or a designated official of the Ministry responsible for the collection of the information review, annually, all reporting requirements to determine:
 - (a) whether the purpose of the reporting requirement remains valid;
 - (b) whether the information actually being collected is in accordance with the purpose of the reporting requirement;
 - (c) whether the information is being used in a manner consistent with the purpose of the reporting requirement; and
 - (d) whether any alternative methods of achieving the purpose of the reporting requirement without using identifiable information are possible.
100. That all mandatory reporting legislation contain a provision that the information collected is confidential and is not to be disclosed to any third party not expressly authorized by the legislation unless the law otherwise requires.
101. That the subject of a report have the right to request that errors be corrected. If the collector

of the information is of the opinion that no correction should be made, a record of the dispute should be attached to the original record and included when a disclosure of the original record is made.

102. That the method of physical security adopted for the information collected reflect the sensitivity of that information in accordance with the following rules:

- (a) only as much information in a personally identifiable form as is necessary to fulfil the purpose of the reporting requirement shall be collected and maintained;
- (b) personally identifiable information should be destroyed as soon as it is no longer useful. Retention schedules should be drawn up taking into account the purpose for which the information is collected; and
- (c) records that are to be stored, such as, for example, communications from a laboratory to a medical officer of health, should be transferred in such a manner that they are never out of the control of a person responsible for their security.

103. That, in the light of the evidence that the purpose for which cases of gonorrhoea must be reported may no longer justify the risk from the invasion of privacy, the requirement of reporting them be carefully and objectively reconsidered.

CHAPTER 29: STUDENT HEALTH INFORMATION

104. That, where a local public health agency enters into an agreement with a board of education to provide inspection or other health services for students of that board of education, the agreement include the following provisions:

- (a) the categories of information collected and maintained in the health record shall be disclosed by the collecting agency on request;
- (b) a parent of a student, or the student, if he or she is 16 years of age or more, has a right to

inspect health information with respect to that student maintained by the local medical officer of health;

- (c) an authorization by a parent, or the student, if he or she is 16 years of age or more, shall be required for the release of health information concerning a student to any person not directly involved in the health care of the student in the collecting agency;
- (d) the medical officer of health may disclose health information the agency maintains about a student without the authorization described in section (c):
 - (i) if, in his opinion based on clinical judgment, the information is necessary to alleviate an emergency affecting the health or safety of a student; or
 - (ii) to the medical officer of health of another local public health agency to within the jurisdiction of which the student has moved, provided that the parent, or the student, if he or she is 16 years of age or more, has been notified of the intended disclosure before it occurs in order that he or she may have the option to prohibit the disclosure;
- (e) any consent to release of information required with respect to health information shall state the period of time during which the consent is valid, the nature of the information to be released, the individuals or authorities to whom the information is to be released, and that there shall be no further disclosure by the receiving individual or authority without the consent of the parent, or of the student, if he or she is 16 years of age or more; and
- (f) the medical officer of health shall be responsible for carrying out procedures necessary to ensure that any health information maintained with respect to a student is timely, accurate and relevant to any health or related requirements of the student for the purposes of his education, or in compliance with public health programmes.

105. That provisions (a) to (f) of the preceding recommendation apply to the manner in which information concerning a student generated by a psychologist employed by a board of education is collected, maintained and released, and for this purpose, the terms, "department of psychological services" and "psychologist", respectively, shall be substituted for the terms, "local public health agency" and "medical officer of health", in the preceding recommendation.
106. That the restrictions and controls to be exercised in connection with student health information apply whether the information is obtained by a physician or any other health-care professional having a direct relationship with students or their parents, and whether or not the professional person is employed by a local public health agency, board of education or other authority. Where the health-care professional involved is an employee of any such authority, the requirements set out in this chapter, as well as the ethical requirements of any professional regulatory body of which that person is a member, should take precedence over any right of access the employer may have, exercises, or attempts to exercise in connection with health information. However, no health-care professional who releases information in accordance with the criteria I have mentioned should, by virtue of that release, be considered or held to be in breach of any rule relating to professional misconduct established by a professional regulatory body.

CHAPTER 30: EMPLOYEE HEALTH INFORMATION

107. That legislation be enacted to make it an offence for an employer to reveal any health information concerning any present or former employee to a third party (unless otherwise required by law) without the consent of the employee.
108. That all health information be stored separately from other employee information.
109. That all persons handling employee health information be given written guidelines relating to the confidentiality of the information. These guidelines, which should be established by the Ministry of Labour in consultation with the Ministry of Health, should

deal with the collection, retention, storage, security, access, disclosure and destruction of identifiable employee health information held by employers.

110. That all health information be kept in cabinets which should be locked and accessible only to those persons directly involved in administering that information.
111. That for an internal transfer of information within the employer, from one department or one section to another, the consent of the employee be obtained.
112. That an employee have a right of access to all of his or her health information held by an employer, including a right to request that corrections be made, if necessary, or a notation of his or her objection.
113. That the results of laboratory testing performed on employees or applicants for employment be sent either to the health personnel (if any) or to the physician requesting the tests. Non-health personnel should not be permitted to open the reports of the test results.
114. That the sending of employee health information outside the Province of Ontario be prohibited unless all identifying information is removed.
115. That where the reason for storing the information outside Ontario is that it be used for epidemiological research in respect of the employer's operations, a code be devised to enable an employee to be identified, but the key to the code must be retained in Ontario.
116. That legislation be enacted to make it clear that a professional employee's duty of confidentiality transcends his or her duty to obey an employer's instructions, where those instructions require the employee to reveal information held in confidence.
117. That the responsibility for the storage and control of health information about employees be declared to be that of the health professionals employed by the employer, or, if there are none employed, a physician designated by the employer.

118. That the employer not be allowed access to health information about an employee without the consent of the employee concerned.
119. That where, in the opinion of a health professional, disclosure of confidential information is necessary because of a clear danger to the employee, fellow employees, or to the product resulting in a danger to the public and
 - (a) the employee concerned consistently refuses to give consent, and
 - (b) a second opinion is obtained from the employee's personal physician when the concern is for the health of the employee, or from the medical officer of health when the risk is to the public or to fellow employees,the health professional may make the disclosure to the proper person at management level after giving notice in writing to the employee, which notice shall indicate the confidential information intended to be disclosed.
120. That the only information which can be given to a prospective employer after a pre-employment medical examination be whether the applicant is fit for the employment.
121. That if an applicant is fit with certain limitations, these limitations must be stated without disclosing the reasons for the limitations, for example, "unable to lift heavy loads or loads above X pounds" or "limited bending".
122. That where a medical department staffed by health personnel is maintained by the employer, the results of the examination be kept in the medical department but not be available to the employer except as recommended in the two preceding recommendations.
123. That where the pre-employment examination is done by a physician not employed by the employer, the employer provide that physician with a job description so that he or she may be aware of the fitness requirements of the position and that a copy of the recommendation be given to the applicant.

124. That the applicant be entitled to a copy of the examining physician's record of examination if he or she so requests.
125. That where the recommendation is that an applicant is not fit for the position an explanation for the recommendation, indicating the reasons, be given to the applicant by the physician making the examination, if so requested.
126. That whenever an employee is required to undergo a periodic medical examination or a medical examination because of a suspected health problem, and as a result an opinion is given that the employee's job should be changed, recommendations 120 to 125 apply.
127. That the Ministry of Labour in consultation with the Ministry of Health prepare a form that will be sufficient to:
 - (a) justify an employee's absence; and
 - (b) certify an employee's fitness to return to work.
128. That the medical department be responsible for accepting medical certificates for short term sickness and advising those responsible for the payment whether or not payment should be made for the period of absence. The certificates should be retained and filed in the medical department.
129. That where there is no medical department,
 - (a) depending on the size and organization of the employer, a senior person in each department, branch or unit be given the authority referred to in the preceding recommendation; and
 - (b) no copies be made of the certificates, which should be kept in a locked cabinet.
130. (1) That where an employee makes a claim on a sickness and accident insurance or other insurance policy provided by the employer the claim form be sent directly to the insurance company and not to the employer.

(2) That the employer be prohibited from requesting a copy of the claim form containing the diagnosis

from either the claimant or the insurance company.

- (3) That a separate form be prepared for employment information necessary to complete the claim.
- 131. (1) That where the employer is a self-insurer or acts as an agent for an insurance company for sickness and accident benefits, documents containing employees' health information be maintained separately from other records maintained by the employer.
 - (2) That the information in these documents not be made available for use in making employment decisions.
 - (3) That access not be allowed to any other employee of the employer, including health personnel, without the consent of the individual concerned.
- 132. That the authorization for release of medical information on a claim form be so phrased as to make it clear that the only information required relates to the disability for which the claim is made.
- 133. That information relating to health and accident claims of employees provided by an insurance company to an employer consist of statistical information only without identifying employees, except when given to the medical department of the employer.
- 134. That where information which identifies employees is given to the medical department, it shall not be available for use in making employment decisions.
- 135. That where the employer maintains a medical department, all requests from the Workmen's Compensation Board for information relating to previous similar disabilities be directed to the medical department.
- 136. That where medical information is forwarded to the Workmen's Compensation Board, a copy be given to the claimant.
- 137. That where no medical department is maintained by the employer, no information relating to previous similar disabilities be forwarded to the Workmen's

Compensation Board without the authorization of the claimant.

138. That where an employer has a medical department, those persons responsible for administering workmen's compensation claims on behalf of the employees be made part of the medical department. The persons who become part of the medical department, with the implementation of this recommendation, should be denied access to other records generated by the medical department.
139. That where there is no medical department, the persons responsible for processing the claims on behalf of the employer ensure that the claims are kept separate from other records on the claimant and are not accessible to other personnel.
140. That where a claim is transferred from workmen's compensation to a claim under sickness and accident benefits or short term illness benefits the claimant be advised and his or her consent be obtained before his or her health information is transferred.
141. That The Health Insurance Act, 1972 be amended to make it possible for any authorized representative of a person personally entitled to information from OHIP to receive any information that person may receive.

CHAPTER 32: THE WORKMEN'S COMPENSATION BOARD

142. (1) That when a report containing medical information about a claimant is sent to the Workmen's Compensation Board pursuant to section 52 of The Workmen's Compensation Act, a copy of the report be sent to the claimant free of charge.
(2) That when in the opinion of a health-care practitioner sending a copy of the report would be detrimental to the physical or mental health of the claimant, an application be made by the health-care practitioner to the Health Commissioner, referred to in recommendation 83, for an exemption from the obligation to forward a copy of the report to the claimant.
143. That section 99 of The Workmen's Compensation Act be repealed.

144. That the claimant and any person he or she chooses to represent him or her be allowed access to the medical records in his or her file at any time, unless a recommendation has been made by the Health Commissioner that it would be detrimental to the claimant to see the records or any part thereof.
145. That where the finding of the Health Commissioner is that it would be detrimental to the claimant to see a particular report, access be allowed to any other report in the Board's file.
146. That the employer and any person the employer chooses as a representative be allowed access to medical records on the file where the Board is satisfied that,
 - (a) there is an appeal from a decision of the claims adjudication branch; and
 - (b) the employer has a genuine interest in the appeal.The access should be restricted to those medical reports or those portions of the medical reports that are relevant to the issue in the appeal.

147. (1) That The Coroners Act, 1972 be amended to allow the coroner to forward to the Workmen's Compensation Board a copy of the post mortem examination report when the report is required by the Board to enable it to determine a claim for compensation by dependants of the deceased.
(2) That where a copy of the report is forwarded to the Board the claimant or his or her representative be allowed to have access to it.
(3) That where an employer is involved in the appeal process the employer and any representative of the employer be allowed access to the report, if it is relevant to an issue in the appeal.
148. That when a medical report is forwarded to any physician by the Board or by the staff physicians at the Board's Hospital and Rehabilitation Centre, a notice to this effect be sent to the claimant.

149. (1) That information given to a company physician relate only to the rehabilitation needs of the claimant or to suspicion of exposure to contaminants used in the manufacturing process of that employer.

(2) That before information about a claimant is given to a company physician, the consent of the claimant to the release of this information be obtained after he or she has been given the opportunity to see what information is being forwarded and to indicate disagreement with any part of it.

(3) That the recommendations relating to employee health information generally apply to information of this kind.

150. (1) That The Workmen's Compensation Act and The Occupational Health and Safety Act, 1978 be amended to allow for an exchange, between the Medical Services Department of the Workmen's Compensation Board and the Occupational Health and Safety Division of the Ministry of Labour, of information that relates to the epidemiology of industrial diseases and of particular disabilities suffered by claimants.

(2) That written guidelines relating to the extent of the exchange of information be prepared by the Workmen's Compensation Board and the Occupational Health and Safety Division.

(3) That any information that is exchanged be subject to the provisions of the respective Acts prohibiting further disclosure.

151. That the subrogation department of the Workmen's Compensation Board refuse to provide any information to private investigators. The department should deal only with licensed insurance adjusters, insurance companies, or solicitors in attempts to settle its subrogated claims.

152. That before the Board releases any medical report it has in its possession to any person, agency or company to further a claim for a pension entitlement or for the payment of monies pursuant to an insurance policy by a claimant, it must have a consent for the

release signed by the claimant. Before being asked to sign the consent the claimant must be given an opportunity to see the report or reports to be forwarded and have an opportunity to indicate what corrections he or she believes should be made. If corrections requested by the claimant are not made, the fact of the request should be noted on the medical records that are forwarded.

153. (1) That when new guidelines are formulated to acknowledge specific illnesses as being industrial illnesses, The Workmen's Compensation Act be amended to allow the Board to obtain from the companies administering the pension plans on behalf of the employees the names of those employees who are suffering from, or have died as a result of, the illnesses.

(2) That where an employer is the administrator of the pension plan on behalf of the employees, the information be obtained from the department or employee of the employer responsible for the administration of the plan.

CHAPTER 33: THE OCCUPATIONAL HEALTH AND SAFETY ACT, 1978

154. That the right of the employees to have access to all their health records generated or maintained within the work place include the right to have access to the results of all biological or other testing required to be done on them.
155. That a worker be advised immediately if the presence of any abnormal or unusual condition is detected by a periodic examination, or by the results of laboratory testing or x-rays, whether work related or not.
156. (1) That, where the employer maintains an occupational health service, a record be kept which shows the dates of visits with an indication of the reason for the visits.

(2) That the joint health and safety committee and the health and safety representative have a right of access to this record.
157. That the joint health and safety committee be allowed access to the results from biological monitoring of

employees required by The Occupational Health and Safety Act, 1978.

158. That the joint health and safety committee or health and safety representative be placed under a duty of confidentiality and be provided with guidelines prepared by the Ministry of Labour in consultation with the Ministry of Health relating to confidentiality of health information generally.
159. (1) That the joint health and safety committee or health and safety representative may not disclose information concerning the health of an employee to the employer or to other employees without the consent of the worker to whom the information relates.
(2) That where the consent of the worker to whom the information relates cannot be obtained because of the death or illness of that person, or because the person is no longer employed by the employer, there be a discretion to release the information if the committee or representative is of the opinion that the health of workers in general is being adversely affected by hazardous conditions in the work place.
160. That, where a trade union receives information under sections 25, 26 and 27 of The Occupational Health Act, 1978, recommendations 158 and 159 above apply to that information in the hands of the trade union.
161. That the present practice of advising the local medical officer of health of an abnormality in an employee detected by testing pursuant to The Occupational Health and Safety Act, 1978 be authorized by an amendment to The Public Health Act or The Occupational Health and Safety Act, 1978.
162. That notice to the local medical officer of health be given when
 - (a) an abnormality is detected in a worker and there is no company or family physician to whom the report may be sent; or
 - (b) because of the work environment there may be a health risk to family members of the worker.

163. (1) That the results of testing of workers for exposure to occupational hazards be sent to the requesting physician and not to the employer.

(2) That the physician interpret the results and advise the employer whether a given worker is fit to continue in the same job and whether any modifications of the employment should be effected.

(3) That the employer may receive a summary of results with a breakdown of the number of abnormalities found among the workers, provided that identifiable information is not included in the summary.

164. That the Industrial Chest Disease Service discontinue the practice of disclosing to employers the names of workers suspected of having contracted tuberculosis.

165. That only inspectors who are physicians working within the Ministry of Labour be allowed to inspect health records in the work place.

166. (1) That the Occupational Health and Safety Division of the Ministry of Labour issue guidelines setting out in what circumstances access to health records in the work place will be sought and the record copied.

(2) That access to these health records by the Division not be conditional upon the consent of the employees who are the subjects of the records, provided the guidelines referred to above are followed.

(3) That the employees to whose records access will be sought be given notice setting out the purpose for which access to the records is sought.

167. That a system of control and physical security of the records in the physical possession of the Occupational Health and Safety Division be established to ensure that their integrity is maintained and that they are unavailable to unauthorized persons.

168. That written guidelines be prepared indicating when and in what circumstances any sharing of identifiable

employment health information with other government departments or agencies might be permitted.

169. That use of the Ministry of Labour's identifiable occupational health information be subject to recommendation 94 relating to research.
170. That a record accessible to the public be kept of all persons or groups requesting access to the Ministry of Labour's identifiable occupational health information for research purposes and of whether such access has or has not been granted.

Summary of Ontario Legislation

The following summary is divided into two parts.

Part 1 attempts to give an overview of existing legislation as it deals with health information with respect to the following matters:

- (a) collection by government and the private sector,
- (b) confidentiality requirements imposed upon government, health-care providers, health-care institutions and private sector handlers of health information,
- (c) access to health information by government inspectors, police, researchers and third parties generally,
- (d) patient access, and
- (e) retention and destruction of health information.

The various types of legislative references, frequency of occurrence, areas of application, and patterns, or lack of them, are outlined.

Part 2 summarizes the legislative background for the sections of the report dealing with:

- (a) employment related health information,
- (b) student health information,
- (c) research and statistical uses of health information, and
- (d) health-care institutions.

In some sections of the report, existing legislation forms an integral part of the discussion (e.g. health-care providers, Ontario Health Insurance Plan, reporting). In others there is very little relevant provincial legislation (police, private investigators). The legislative provisions in these subjects

are referred to only in the general overview provided in Part 1.

Much of the legislation to be referred to is in the form, not of statutes, but of regulations which, of course, have the force of law. The generic word "legislation" includes, in the discussion that follows, both statutes or Acts of the Legislature and regulations. Reference will be made only to the names and relevant section numbers of the various pieces of legislation. The full citations of the statutes and regulations which are the subject of this section of the report have been reproduced in the Schedule which will be found after the endnotes to this summary. The statutes and regulations referred to in this summary include all legislation and amendments in effect as of January 1, 1980.

PART 1—OVERVIEW OF EXISTING LEGISLATION

Approximately 500 Ontario statutes are now in force. Of these, 77 (or regulations made under them) have been considered appropriate for inclusion in this summary. These 77 pieces of legislation refer variously to the reporting, collection, storage, use, dissemination, confidentiality, retention or disposal of health information. The Ministry of Health has responsibility for 22 of these Acts[1], while other Ministries administer the remaining 55.

The legislative treatment of health information is extremely inconsistent. When gathered together, the relevant sections may appear to comprise a formidable body of law. However, in this case, the whole is not greater than the sum of its parts. The whole is merely a collection of piecemeal provisions. No general code is established for the handling of health information. No comprehensive policy is reflected in the present legislation.

For example, the regulations under The Charitable Institutions Act[2] require all staff of these institutions to be "of suitable age, health and personality to carry out his duties". No definition of suitable health is given. A physician's certificate is required, but whether this is to be a simple statement of suitability or a detailed medical report is not stated. Similarly, no definition of suitable personality is given. There is silence with respect to whether a psychological or psychiatric assessment is required or may be administered, and the nature of the proof, if any, which is to be provided to the employer. There is no indication of who is to handle the health information, how it is to be stored, how long it is to be

kept, other uses to which it may be put, or who is to have access to it (e.g. personnel, payroll, supervisors, medical researchers, government departments, insurance companies, credit reporting agencies, relatives, hospitals, other physicians, or the employee himself or herself). This vague type of provision is fairly typical and can be found in at least 10 statutes or regulations[3].

By way of contrast, other legislation contains very specific and detailed provisions concerning the handling of one particular piece of health information. The regulations under The Private Hospitals Act[4], for example, contain an entire page of provisions dealing with employee tuberculosis tests and results. It is interesting to note, however, that the Act and regulations fail completely to deal with the handling of the vast amounts of health information generated in the course of the hospital's activities, accumulated in the course of complying with the statute, or obtained by government in the course of administering the legislation.

In virtually all of the legislation considered here, there is some basis for the collection of health information, either through the granting of powers of inspection of records, reporting provisions[5], or requirements that health information be produced as a precondition to carrying out some activity. This collection of information is done by both public and private sector bodies.

Of the 77 statutes and regulations included in this summary, 33 have some particulars as to records to be kept. Retention, storage or disposal of records are directly referred to in 11 of them[6], but only one contemplates the method of destruction of records[7].

Only 35 statutes or regulations contain any confidentiality requirements[8]. The provisions that do exist are usually specifically directed at one group and rarely apply to all persons who might acquire health information as a result of activity in connection with the legislation. For example, civil servants who administer The Ambulance Act have a statutory duty of confidentiality[9], but employers who acquire employee health information under the Act have no similar duty.

Most dealings with health information are not covered in any way by legislation. As a result, and as a result of the inconsistencies present in the legislation that does exist, some of the textual statements that follow are supported by anecdotal or illustrative references to relevant legislation, rather than by exhaustively setting out all of the statutory materials.

A review of the many situations in which Ontario legislation authorizes the collection of health information follows. This may provide a context for, and a better appreciation of, the legislative provisions regarding the actual handling and confidentiality of such information.

Collection of Health Information by Government

Inspection. Government appointed inspectors may have access to health information in the exercise of their statutory powers to examine files and records. At least 53 of the 77 statutes and regulations included here contain such rights. Among others, the following may be subject to having their records inspected:

- (a) professional and non-professional health-care providers[10],
- (b) hospitals for physical and mental health care[11],
- (c) children's aid societies[12],
- (d) day care centres[13],
- (e) old age homes[14],
- (f) nursing homes[15],
- (g) boarding homes[16],
- (h) educational establishments[17],
- (i) employers[18], and
- (j) recipients of government grants[19].

Inspections are carried out in order to substantiate services provided, monitor compliance with legislative or policy standards, in the process of peer review (e.g. The College of Physicians and Surgeons of Ontario), or in the course of special investigations such as those carried out under The Public Inquiries Act, 1971.

The majority of the 53 pieces of legislation with inspection sections also contain penalties for failing to comply with inspectors' requests, or for obstructing inspectors in their work.

Reporting. Mandatory reporting of health information upon the occurrence of certain events or when knowledge is obtained (e.g. a physician discovering a carrier of venereal disease is required to report this[20]), is demanded in 33 Acts or regulations. The reporting of health information when government agencies request it is required by 21 statutes or regulations[21].

Penalties for failing to report vary, from a possible fine of \$25,000 or 12 months imprisonment, or both, under the general offence section of The Occupational Health and Safety Act, 1978[22], to the \$100 maximum fines for failure to report under The Highway Traffic Act[23], The Venereal Diseases Prevention Act[24], or The Vital Statistics Act[25]. Two-thirds of the Acts with reporting provisions contain some penalty for failing to comply.

Much of the reporting legislation relieves those persons who report of any civil liability, provided, of course, that the reporting is done in good faith and in intended compliance with the statute.

Voluntary Submission of Information to Obtain Benefits. A great deal of health information comes into government hands as a result of its administration of various benefit schemes and licensing programmes, as well as public interest services and insurance plans. In many cases, participation in the programmes is not mandatory, but if one does participate, there are legislative requirements that health related information be submitted to government agencies.

Some examples of these government programmes are:

- (a) the Ontario Health Insurance Plan[26],
- (b) educational services (elementary, secondary and special)[27],
- (c) social assistance (including vocational rehabilitation)[28],
- (d) workmen's compensation[29],
- (e) driver licensing[30], and
- (f) taxing schemes and deductions[31].

Collection of Health Information by Non-Governmental Entities

Some Ontario legislation requires private sector entities to collect health information in the course of their activities. Other legislation simply gives the private sector the power to collect this kind of information. Some examples follow for the purposes of illustration:

- (a) employers are required to gather data regarding certain types and categories of workers[32],
- (b) private schools have statutory duties to monitor the health of pupils and teachers[33],
- (c) review committees or disciplinary bodies of health-care providers are given access to patient health data for purposes of their deliberations[34],
- (d) insurance companies have a statutory right to insist on production of health information relevant to certain types of policies, and the statute relieves the companies from liability under the policies where full disclosure is not made[35], and
- (e) consumer reporting agencies are allowed, in certain situations, to collect and pass on health information[36].

Confidentiality of Health Information in Ontario Legislation

No consistent treatment or coherent policy regarding the confidentiality of health information is reflected in Ontario legislation. Of the 77 statutes and regulations in this study, 35 contain some form of confidentiality provision. Of the many different categories of persons who handle health information in this province, only 3 groups are subject to statutory duties of confidentiality[37], and only some members of each group are affected. Some health-care professionals, some government administrators and inspectors, and some health-care institutions have duties in this connection.

Duties of Health-Care Professionals. Legislation imposes a confidentiality obligation upon 5 categories of health-care professionals. Dentists[38], physicians[39], optometrists[40], and denture therapists[41] must not disclose information without patient consent, unless required to do so by law. Registered nurses and nursing assistants[42] must exercise discretion in the disclosure of patient information. Breach of these

obligations constitutes professional misconduct which may be investigated by the governing bodies of the respective disciplines. Penalties may be imposed ranging from reprimand to suspension or revocation of a licence to practise.

Among the numerous health-care workers who do not have a statutory duty of confidentiality are those governed by The Drugless Practitioners Act, including such groups as chiropractors, physiotherapists, osteopaths and masseurs. The legislation that regulates psychologists contains penalties for professional misconduct, but the definition of misconduct does not specifically refer to breach of confidentiality[43]. Persons such as radiological technicians, social workers, medical records clerks and others who may have access to health information are not bound directly by an obligation of confidentiality, although in some cases their employers may have duties of that kind[44].

Duties of Administrators, Inspectors. Fifteen statutes or regulations have some form of requirement that administrators and those making inspections or inquiries under the Acts (including advisory and governing boards and committees) keep secret the information acquired in the course of their work[45]. The provision of health care and other services is regulated by 7 of these Acts or regulations. Only 5 of the 7 impose a similar obligation on those who are regulated [46], and only 3 of the 15 Acts or regulations specifically extend the secrecy obligation to employees[47].

The stringency of the confidentiality requirements varies greatly in the legislation. For example, The Health Disciplines Act, 1974 states that "every person employed in the administration" of Part III of the Act (Medicine) "shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties" and provides for only limited exceptions[48]. The Child Welfare Act, 1978 requires secrecy only in relation to the child abuse register[49]. The Family Benefits Act, under which very sensitive health information is sometimes gathered, contains no confidentiality requirement whatever. The regulations under The Vocational Rehabilitation Services Act go so far as to include a form specifically containing an authorization for release of medical information about an applicant[50].

Apart from any particular statutory secrecy requirement, some protection is afforded health information collected under all Ontario legislation. Every Ontario civil servant is required to take an oath of secrecy in the following form[51]:

"...except as I may be legally required, I will not disclose or give to any person any information or document that comes to my knowledge or possession by reason of my being a civil servant. So help me God."

The protection provided by this oath is of very questionable value, however. Breach of the oath is not an offence which can be prosecuted. Apparently administrative discipline or dismissal might follow the breaking of the oath, but no record could be found of the dismissal of any Ontario civil servant for this reason. In addition to the general oath, 6 statutes or regulations included in this study provide for some oath of secrecy to be taken prior to employment or prior to access to information under the Acts[52]. The only penalty attached to breach of these oaths is under The Audit Act, 1977, which specifically provides for dismissal[53].

Duties of Health-Care Institutions. Of the 20 statutes regulating health-care institutions such as mental health facilities, physical care facilities, and residential and custodial services, only 6 provide any form of safeguard for the protection of health information in the patient or resident records[54]. The other 14 statutes provide no protection[55].

The statutes and regulations governing the various health-care institutions differ radically in their treatment of patient records[56]. The 6 Acts and regulations with confidentiality provisions are reviewed below.

Regulation 729 under The Public Hospitals Act makes the medical record confidential, but allows the following persons or bodies access to the record: inspectors, courts, coroners, The College of Physicians and Surgeons. The hospital board may, in its discretion, also allow access by the following: the attending physician, other public hospital administrators, a person with patient consent (or that of the personal representative or guardian), medical staff for approved research and teaching purposes, Veterans' Affairs (Canada), the Ontario Ministry of Health and, with ministerial approval, release to a haematology users' data bank[57]. Regulation 196/72 under The Nursing Homes Act, 1972 has similar provisions, except for the 4 last-mentioned categories[58].

The Mental Health Act is applicable to more than 160 hospitals, clinics and institutions in Ontario[59]. Section 26a of the Act was enacted in 1978, and states that "no person shall disclose, transmit or examine a clinical record", with the following exceptions: with patient consent (or that of the

nearest relative of a minor or mentally incompetent patient), psychiatric staff, head of a health-care facility treating the patient, any person for research, academic or statistical use provided that patients are not identified by this use, and the courts.

In the regulations under The Homes for the Aged and Rest Homes Act and The Training Schools Act, particular administrators are given the responsibility for ensuring the confidentiality of the records of the residents[60]. No further criteria are set out regarding who shall and shall not have access to the records. Breach of confidentiality is not an offence.

The Private Sanitaria Act requires members of the board of visitors to take an oath of secrecy. The effect of this oath is somewhat undermined by language which allows a board member to disclose information "so far as I feel myself called upon to do so for the better execution of the duty imposed upon me by the said Act"[61]. Again, no offence is committed if the oath is breached. Ontario legislation regarding health-care institutions and the confidentiality of health information is clearly inadequate.

Finally, one type of health information is especially protected by the legislation. The Venereal Diseases Prevention Act contains very stringent confidentiality provisions[62]. Administrators of the Act must keep secret information acquired in the course of their work. Laboratory reports are to be disclosed only to physicians and those administering the Act. Where municipalities provide venereal disease treatment facilities, every local board of health must keep secret the name of any person who has received treatment, designating accounts by number, not name. Every person who makes any form of statement concerning the existence of the disease in another, except in good faith, or in evidence in any judicial proceedings or in compliance with the Act and regulations, is guilty of an offence. Unauthorized disclosure of venereal disease information is punishable by a fine of \$200 (which amount has not been increased since the legislation was first enacted in 1918) and in default of immediate payment, by imprisonment for up to 6 months. Civil servants who breach their confidentiality obligations under the Act are also to be dismissed from their employment.

Penalties for Breach of Confidentiality. Of the 35 statutes and regulations containing some form of confidentiality provision, 24 allow for a possible penalty for breach of either the particular provision or for any breach of the Act and

regulations. The following lists the statutes and the possible penalties.

<u>The Ambulance Act</u>	\$1,000 (\$10,000 corporations)
<u>The Audit Act, 1977</u>	Dismissal
<u>The Child Welfare Act, 1978</u>	\$1,000 or 1 year or both
<u>The Consumer Reporting Act, 1973</u>	\$2,000 (\$25,000 corporations)
<u>The Denture Therapists Act, 1974</u>	Reprimand, licence revocation, suspension or restriction
<u>The Energy Act, 1971</u>	\$10,000 or 1 year or both
<u>The Funeral Services Act, 1976</u>	\$2,000 (\$25,000 corporations)
<u>The Health Disciplines Act, 1974</u>	\$2,000 (civil servants) Practitioners: reprimand, licence revocation, suspension, restriction or \$5,000
<u>The Health Insurance Act, 1972</u>	\$2,000
<u>The Highway Traffic Act</u>	\$100
<u>The Human Tissue Gift Act, 1971</u>	\$1,000 or 6 months or both
<u>The Income Tax Act</u>	\$200
<u>The Liquor Licence Act, 1975</u>	\$10,000 or 1 year or both
<u>The Mental Health Act</u>	\$10,000
<u>The Nursing Homes Act, 1972</u>	\$2,000
<u>The Occupational Health and Safety Act, 1978</u>	\$25,000 or 1 year or both
<u>The Ontario Guaranteed Annual Income Act, 1974</u>	\$300
<u>The Police Act</u>	Dismissal, demotion, reprimand, etc; \$500 or 1 year or both

<u>The Private Investigators and Security Guards Act</u>	\$2,000 or 1 year or both (\$25,000 corporations)
<u>The Public Hospitals Act</u>	\$500
<u>The Statistics Act</u>	\$300 or 6 months or both; (\$5,000 or 5 years or both for speculation)
<u>The Venereal Diseases Prevention Act</u>	Dismissal (civil servants) \$200 or 6 months
<u>The Vital Statistics Act</u>	\$200
<u>The Workmen's Compensation Act</u>	\$50

Confidentiality Provisions in Health Insurance Legislation

The inclusion of confidentiality provisions in health insurance legislation is a relatively recent development. The first comprehensive confidentiality requirements were not introduced until 1968-69. The provisions now in force will be outlined below, followed by a description of previously existing requirements. First, the present powers to collect health information in the context of the Ontario Health Insurance Plan will be described briefly.

Legislative Authority to Collect Information. The Health Insurance Act, 1972 contains a number of sections authorizing the collecting of health information. The Minister has a general power to authorize surveys and research programmes and obtain statistics for purposes related to the Plan. Every physician or practitioner in the Plan is required to submit particulars of his or her services and accounts to the General Manager. This disclosure is deemed to have been authorized by the patient and no action lies against anyone required to provide the information[63]. Similar provisions were contained in the predecessor statute, The Health Services Insurance Act, 1968-69[64]. The General Manager may also order inspections of the records of employers of mandatory groups and collectors[65]. Other provisions are found in Regulation 323/72 regarding information to be supplied by employers, administrators of public assistance schemes and designated hospitals[66]. The Medical Review Committee of The College of Physicians and Surgeons of Ontario may order inspections of the medical and financial records of persons and institutions involved in the Plan, and similar powers are given to practitioner review committees. Obstructing inspectors is an offence under the

Act[67]. It is also an offence for anyone knowingly to furnish false information in relation to the Plan[68].

Present Confidentiality Provisions. The Health Insurance Act, 1972 also dictates to whom and in what circumstances information can be given out regarding participants in OHIP, and regarding the operation of OHIP itself. The basic rule is that each person involved in the administration of the statute or regulations, including members of the Medical Review Committee, Medical Eligibility Committee, Appeal Board and practitioner review committees, and employees thereof, "shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment or duties"[69]. Three types of exception to the general rule are then provided for:

- (1) The Ministry of Health is allowed to release any information in statistical form if patients' names and identities are not revealed.
- (2) Information concerning for whom, by whom, where and when insured services were provided, and amounts of money involved, may be provided by administrators of the Plan in the following cases only,
 - (a) in connection with the administration of these Acts:
The Health Insurance Act, 1972,
The Medical Act (superseded by The Health Disciplines Act, 1974),
The Public Hospitals Act, The Private Hospitals Act, The Ambulance Act,
Hospital Insurance and Diagnostic Services Act (Canada),
Medical Care Act (Canada),
Criminal Code (Canada),
 - (b) in proceedings under The Health Insurance Act, 1972 or its regulations,
 - (c) pursuant to a subpoena of a court of competent jurisdiction, and
 - (d) to the persons providing or receiving the insured services, or legal representatives of these persons.
- (3) The General Manager of the Plan may provide information to the statutory governing body of the professional person who provided the insured service.

A summary conviction offence (now, a "provincial offence") is created by The Health Insurance Act, 1972, punishable by a fine of up to \$2,000 for breach of any provision of the Act or regulations[70]. Presumably, contravention of any of the confidentiality provisions of the Act would be an offence. There are no confidentiality provisions governing private insurers who provide supplementary benefits, and who are registered under other provincial statutes.

Earlier Confidentiality Provisions.

(a) Medical Services Insurance--The forerunner of the existing provisions can be found in The Health Services Insurance Act, 1968-69. In one way, these confidentiality provisions were not as sweeping as those now in force, in that only insured services and payments are referred to, without specific mention of information relating to insured persons. In other respects, however, the previous provisions were stricter than the present ones. The 1968-69 Act allowed information to be released for purposes of the administration of only two statutes, The Health Services Insurance Act, 1968-69 itself and the Medical Care Act (Canada)[71]. In 1971, The Medical Act, now replaced by The Health Disciplines Act, 1974, was added to the list[72]. The 1968-69 Act also stated that no person engaged in the administration of the Act could be compelled to give testimony in civil cases[73]. That discretion not to testify has been removed, and providing information pursuant to a subpoena is expressly permitted in the current statutory scheme. The remainder of the provisions paralleled the existing confidentiality sections, including the general offence section and penalty of up to \$2,000.

(b) Hospital Services Insurance--Prior to 1968-69, the only confidentiality provisions relating to hospital or medical services insurance were to be found in The Hospital Services Commission Act, 1956[74] and Regulation 239, R.R.O. 1960, made under that Act. The Act established the Ontario Hospital Services Commission. No general confidentiality section existed in the statute. No member of the Commission or employee could be compelled to give testimony in any civil action or proceedings, and no information could be required to be produced as evidence in any civil action or proceedings, if that information had been obtained by the Commission from a hospital or obtained from any statement made to inform the Commission about an incident that caused an insured person to require care and treatment in a hospital[75].

Regulation 239 contained confidentiality requirements relating only to owners or supervisors of nursing homes for chronic care. Access to information had to be allowed to inspectors under the Act and persons with a process from an

Ontario court. Those in charge of medical records were given discretion to allow access by a person with patient consent (or that of the personal representative), the attending physician, hospital superintendents, the Director of the Division of Medical Statistics of the Ministry of Health, and, if the patient was a member or ex-member of the armed forces, to the Deputy Minister of Veterans' Affairs (Canada)[76].

In sum, prior to the unification of administration of hospital services and medical services insurance in 1972, the legislative requirements for confidentiality in the hospital-insurance field were very limited.

Access to Health Information

The concept of access to health information, as used in this section, has been limited to those cases in which some person or agency holds information about an individual and the statutes or regulations provide for some other party to have access to that information. In this context, the individual who is the subject of the records may be in the position of seeking access to the information about himself or herself.

Access by Government. This subject has been partially canvassed under the heading, Collection of Health Information by Government[77]. Exchanges of information among levels of government are not often referred to in Ontario legislation. Regulation 820 under The Vital Statistics Act contemplates the sharing of information with representatives of the federal and foreign jurisdictions, provided the recipient takes an oath of secrecy[78]. The Statistics Act requires the consent of the person who has supplied the information before it can be transferred in identifiable form[79].

Very specific pieces of information are allowed to be shared with the federal government under Regulation 729 under The Public Hospitals Act (data concerning present and former members of the armed forces)[80], and The Child Welfare Act, 1978 (information regarding services for, or care and protection of children, pursuant to interprovincial or federal-provincial agreements)[81]. Health information may also be passed to the federal government under agreements made pursuant to The Income Tax Act[82] or The Ontario Guaranteed Annual Income Act, 1974[83].

Access for Statistical and Research Use. This type of use is expressly referred to in 11 statutes or regulations which are administered by the Ministry of Health[84], and in 8 others

which are the responsibility of other ministries[85]. Ministerial control over, or the approval of the Lieutenant Governor in Council regarding, surveys and statistical use of health information is generally provided for in the legislation[86]. The legislation contemplates the following persons or organizations carrying out statistical or research work and having access to individually identifiable information:

- (a) the Ministry of Health (responsible for OHIP and general research),
- (b) The Ontario Cancer Treatment and Research Foundation,
- (c) The Ontario Mental Health Foundation,
- (d) governing bodies of dentists, denture therapists, physicians, funeral directors, nurses, optometrists and pharmacists, and
- (e) persons involved in research, academic pursuits and the compilation of statistical data.

With respect to research and statistical use of health information, there are no provisions for obtaining the patient's consent to the use of information relating to him or her, except for the extrajurisdictional transfers referred to in The Statistics Act[87].

Access by Police. With 2 very minor exceptions, our legislation apparently treats health information no differently than any other kind of information as far as the police are concerned[88]. No provincial statutes specifically grant holders of health information any immunity from compliance with search warrants held by the police[89].

Access by Patients. In Ontario patients have very limited rights of access to health information about themselves. Only 6 statutes and regulations expressly confer such rights, and the information to which access is granted is restricted in scope.

As a general rule, physicians and dentists are required by law to provide some information to their patients. The regulations under The Health Disciplines Act, 1974 declare it to be unprofessional conduct for these health-care professionals to fail to provide (without cause and within a reasonable time) "any report or certificate requested"[90]. This is not a direct right of access. No right is conferred upon the patient or his representative. The patient's access to his or her entire

medical record is not contemplated. Only certificates and reports must be provided. The vague term "report" is undefined in the Act and regulations[91].

The second access provision of general application to patients is found in The Health Insurance Act, 1972[92]. Information regarding the date and type of insured service may be obtained by the patient. A severe limitation is that diagnostic information is not included in the available material.

The remaining 4 instances of subject access to his or her own health (or health related) information are:

- (a) Regulation 38/73 under The Education Act, 1974 allows pupils or legal representatives access to the pupil record, which may contain health information[93].
- (b) The Private Sanitarium Act gives former patients or their solicitors access to copies of the certificates or requisitions for detention[94].
- (c) Persons registered in the child abuse register maintained under The Child Welfare Act, 1978 are entitled to access to entries concerning them. The same Act allows the subjects of court ordered psychological assessments to obtain copies, although the court may deny access to children, if advisable[95].
- (d) The Occupational Health and Safety Act, 1978 gives workers access to certain types of information concerning their exposure to toxic substances in the work place as may be prescribed[96].

Access by Third Parties Generally[97]. An Act or regulation may give third parties an express right to certain information. Our research disclosed only 4 examples of this[98]. Legislation may confer on Ministers of the Crown, or government officials or appointees, a discretion to disclose information to third parties. Provisions of this kind are found in at least 21 Ontario statutes. Sixteen Acts give a discretion to disclose information to third parties if the subject's consent is obtained (or if disclosure is required in the administration of the Act)[99]. In the other 5 Acts, there is no reference to the obtaining of consent of the subject of the information[100].

Nothing in these statutes gives third parties a right to insist on the disclosure of health information, even if the consent of the subject is obtained. Neither can the subject

himself or herself compel disclosure. Provisions of this kind only give the holders of the information the authority to disclose it, should they choose to do so.

Many statutes restrict the rights of third parties to have information produced for use in court or administrative proceedings. In general terms, the rule is that the courts may compel anyone to appear and give evidence relevant to the issue in dispute. This includes the production of health information. Some Acts limit this rule by expressly declaring that certain holders of information may refuse to give evidence in court or other proceedings[101].

Of the 77 statutes and regulations in this summary, 13 give civil servants, and others involved in the administration of the various Acts, the right to refuse to produce evidence in legal proceedings[102]. These sections could be used to deny third parties and the courts access to health information held by the provincial government[103].

Retention, Storage and Disposal of Health Records

Although at least 33 Ontario statutes and regulations refer to the collection of health information or the keeping of health related records, only 11 include any provisions for the retention, storage or disposal of these records[104]. Most of this legislation imposes no duties on the record holder concerning the duration of retention, the method and location of storage, or disposal criteria and practices. Adequate security precautions are discussed only in the regulations dealing with records of pupils and public hospital patients.

School Records. The pupil-records regulation under The Education Act, 1974 is the only one to specify where permanent records are to be stored[105]. The regulation establishes safeguards for the maintenance and disposal of transferred records, and provides for the return of certain records to their point of origin in the Ontario school system for long term protection. Although original records may be destroyed after micro-recording for storage and retention for 70 years[106], the method of destruction is not specified.

Patient Records--Health-Care Institutions. Regulation 729 under The Public Hospitals Act provides for the retention of copies of specified reports which form part of the medical record by at least 5 hospital departments[107], for periods of 1 to 5 years [108]; for retention of the complete medical record for 5 to 50 years[109]. The medical record may be photographed

for storage in accordance with procedures established by the hospital board[110]. Destruction must be carried out in accordance with board approved methods and is the responsibility of the administrator[111]. The administrator is similarly responsible for the destruction of departmental records[112], in all but 2 instances[113].

Regulation 196/72 under The Nursing Homes Act, 1972 is the only other statute or regulation in this category to specify duration and retention criteria. Patient records are to be retained for 20 years from date of discharge or 5 years from date of death[114].

Patient Records--Health-Care Professionals. Dentists, physicians, optometrists and pharmacists are required to retain their patient records for periods of from 2 to 10 years or until the professional ceases to practise, whichever first occurs[115]. Only pharmacists have a specific duty to dispose of certain records. Prescriptions are to be delivered to the persons who presented them, to another pharmacy or to the Ontario College of Pharmacists[116].

Employee Health Records. The 6 pieces of legislation which detail employee health-record retention[117] generally specify only that they be retained for periods of 6 months[118] to 5 years[119] after termination of employment.

Other Provisions. At least 2 statutes specifically require that relevant records not be destroyed once an investigation under the Act has commenced[120]. Also under The Income Tax Act certain records are to be retained until permission for their disposal is obtained[121]. Five statutes and regulations provide for the disposal of records when the service provider or employer has ceased operations, by sending them to the regulating Ministry[122].

Government records generally are covered by The Archives Act which requires that "all original documents...records and other matters in the executive and administrative departments of the Government...or of any commission, office or branch of the public service shall be delivered to the Ministry of Culture and Recreation for safekeeping and custody within twenty years from the date on which such matters ceased to be in current use"[123] and that no branch of the public service shall destroy or permanently remove any official document, paper or report without the concurrence of the Archivist[124].

PART 2—LEGISLATIVE BACKGROUND OF SELECTED REPORT CHAPTERS

Occupational Health and Safety: Employment-Related Health Information

Introduction. There are specific legislative references to employment related health information in the following contexts:

- (a) ensuring that employees are mentally or physically suitable for particular jobs,
- (b) ensuring that employees are protected, within certain limits, from dangers in the work place, (The Occupational Health and Safety Act, 1978),
- (c) providing for compensation for work related injuries and illness (The Workmen's Compensation Act),
- (d) providing in some instances a statutory right to sick leave benefits, and
- (e) ensuring that the public is not endangered by disease-bearing employees (The Public Health Act).

Ontario legislation generally does not direct how an employer is to handle the information which is generated. The legislation, in most cases, is silent concerning an employee's access to his or her own medical file, and on questions of collection, transfer, ownership and confidentiality of employee health information.

With respect to workmen's compensation, occupational health and safety, and public health, governmental agencies have been created to administer and monitor compliance with the legislation. These agencies, like all government bodies, may only do those things for which they have statutory authority. They are given statutory rights of access to employee records in order to carry out their functions. The agencies dealing with workmen's compensation and occupational health and safety are subject to a duty to keep information confidential. The public health authorities, however, have no similar obligation under The Public Health Act.

The existing legislation reflects no coherent policy regarding the handling of employee health information. Persons dealing with this type of information are generally left to their own devices without any statutory direction or

restrictions. The provisions that do exist are isolated exceptions to this general rule. These exceptions are listed below:

- (a) personnel records of nursing homes may not be removed, except by an inspector[125],
- (b) The Occupational Health and Safety Act, 1978 prohibits any person from disclosing individually identifiable medical information[126],
- (c) former public hospital employees are entitled to have their tuberculosis tests and x-ray results[127],
- (d) a number of health-care providers are subject to a duty of confidentiality through professional codes of conduct[128], and
- (e) apart from the provisions of the Acts governing occupational health and workmen's compensation (discussed below), many civil servants are subject to duties of confidentiality which are not specifically directed towards health information[129].

Statutory Health Requirements for Particular Employment. As the chart on the following page indicates, many categories of employees have some health requirement to fulfil, either physical or mental. Except in The Occupational Health and Safety Act, 1978, health requirements are not necessarily linked to the type of work performed. For example, a comprehensive medical examination is required for public hospital employees, laboratory workers and "all other hospital employees", including, presumably, secretaries, telephone operators, accountants and administrators[130]. Employees in private hospitals, on the other hand, need only have a tuberculosis test to perform the same functions[131].

The Occupational Health and Safety Act, 1978. The section of the report dealing with this Act examines some of the particular provisions of the statute in detail, and considers the question who should have access to the information generated under the Act. In order to provide a broader context for that discussion, a description of the general scheme of the Act is given here.

The intent of the Act is to provide a vehicle for the setting of safety standards to be met in the work place and also to establish institutional mechanisms for monitoring and enforcing compliance with the prescribed standards. The aspects of occupational health and safety dealt with by the Act include

<u>EMPLOYEES—STATUTORY HEALTH REQUIREMENTS</u>	Communicable Disease	T.B.	Physical	Sick Leave Certificate	Mental Health Personality
Ambulance Attendants.	x C	-	x	-	x
Charitable Institutions: Administrator and staff.	x C	x C	x C	-	x
Children's Institutions: Superintendent and staff.	x C	x C	x C	-	x
Children's Residential Services: Operator and staff.	x C	x C	x C	-	x
Day Nursery staff and inspectors.	x C	x C	x	-	x
Day Care Providers.	-	-	x C	-	x
Teachers.	x C	x C	x	x C	x
Homemakers.	-	-	x C	-	x
Homes for Aged and Rest Homes: Administrator and staff.	x C	x C	x C	-	x
Homes for Retarded: Superintendent and staff.	x C	x C	x C	-	-
Homes for Special Care: Superintendent & staff.	x C	x C	x C	-	-
Mental Hospital Staff.	-	x C	-	-	-
Nursing Homes: Administrator and staff.	x C	-	x C	-	x C
Police.	-	-	x C	-	x C
Private Hospital employees.	-	x C	-	-	-
X-ray workers.	-	-	x C	-	-
Meat Plant workers.	x C	-	-	-	-
Waiters, Food Premises employees.	x C	-	-	-	-
Specimen Centre staff.	x Cleanliness Cert.		-	-	-
Food Processing workers.	x C	-	-	-	-
Public Health employees.	-	x C	x C	x C	-
Ontario Civil Servants.	-	-	-	x C	-
Maternity Leave applicants.	-	-	-	x C	-

x = requirement of a statute or regulation
C = certification required

structural safeguards, worker exposure to toxic substances and general health and safety precautions. The Act itself is relatively general, with details of standards in particular areas to be set out in regulations.

The Act is capable of being applied to almost any employee or group of employees in the province. The only 2 clear exemptions are work related to a private residence done by the owners, occupants or their servants, and work done by prisoners or mental patients in the course of a rehabilitation programme[132].

The Minister of Labour or Lieutenant Governor in Council may, by order or regulation, include or exempt any class or sub-class of employer or employee[133]. It appears that the Act is not intended to apply, in the normal course of events, to such categories as teachers, farmers, office workers, retail sales help and cultural centre employees, but even these may be included by order or regulation[134]. "Employer" is defined to include those with "one or more" workers[135]. A "worker" is anyone who does anything for compensation, including civil servants[136], and "work place" is anywhere a worker works[137].

The detailed provisions required to put the intent of the Act into effect are to be declared by regulation[138]. However, the usual scheme of the Act requires that a health and safety representative or committee be established in work places where there are regularly more than 20 workers. The principal duties of these agents are to inspect the work place, identify hazards and report, with recommendations, to the employer and workers. The Ministry of Labour monitors these activities[139]. Health and safety representatives and committees have the additional responsibility of inspecting sites of serious or fatal accidents and reporting to the Ministry of Labour[140].

Employers have several statutory obligations that relate to worker health information. They may be required to set up an employee health service and to ensure that workers undergo prescribed medical examinations, tests and x-rays, at the expense of the employer[141]. Workers have a corresponding duty to have the prescribed tests, etc.[142]. The Act contains no provision regarding worker access to the health records so generated, as opposed merely to receiving a physician's certificate stating that a worker has been satisfactorily examined.

An employer has a duty to monitor toxic substances in the work place generally and to post the exposure levels[143]. The exposure records of an affected worker must be made available to that worker[144].

Employers are required to give notice to the Ministry of Labour, health and safety representatives or committees and unions if a worker is killed, injured or suffers from an occupational disease[145]. In cases of death or critical injury, the employer is required to send a full written report to the Ministry of Labour[146].

The Ministry of Labour has the right to inspect and copy all the records of an employer[147]. Presumably worker health records are available under this power. It is an offence to obstruct or give false information to an inspector[148].

Worker health information might be available to the Ministry of Labour through the investigations and reports of the permanent Advisory Council established by the Act[149], or reports of special investigating committees which the Minister may appoint[150].

Except for the purposes of the Act, or as required by law, no person (including inspectors, other government employees, employers, health and safety representatives or committee members) shall disclose any health information in individually identifiable form[151]. This strict duty is somewhat undermined by a discretion given to certain Ministry of Labour officials to communicate any information in any form, to any person[152]. Breach of any section of the Act or regulations carries a possible penalty of a fine of \$25,000 or one year imprisonment or both[153].

The Workmen's Compensation Act. There is little to be said concerning the statutory framework for the activities of the Workmen's Compensation Board with regard to health information. The Board has extensive authority to make regulations governing the conduct of its affairs. However, as noted by Professor Ison, few regulations exist. Most activities are governed simply by policy[154].

Under the Act, notice of injury must be given to the employer and the Board[155]. If the employer is privately insured, notice is to be given to the insurance company of the claim for compensation[156].

An authorized officer of the Board may inspect the medical records of an employee at any time, according to regulations made under The Mental Hospitals Act, The Private Hospitals Act and The Public Hospitals Act[157]. The same regulations provide for mandatory reporting to the Board and for the giving of information to the Board on request in certain circumstances.

There are no provisions regarding notice to, or obtaining the consent of, the subject employee.

The Workmen's Compensation Board is not limited to obtaining health information through notice provisions and inspection powers. The Board may demand health information from any persons who have provided health care for the claimant[158], and the Board has broad powers to compel testimony and evidence at any hearing[159].

All information in the Board's hands must be kept confidential by the staff of the Board, but it appears that the Board itself may waive the confidentiality relating to certain information[160]. Medical reports in the hands of the Board are declared to be inadmissible as evidence in proceedings against the maker of the report, unless it can be proved that the report was made maliciously[161]. This, of course, is a very limited form of confidentiality, and restricted to a very narrow range of proceedings.

There are no provisions regarding confidentiality or otherwise of information in the employer's hands, although an employer may require a claimant to submit to a medical examination and receive the report[162].

Sick Leave Under Ontario Legislation.

(a) General Provisions--Absence from employment because of illness is dealt with in only 5 statutes or regulations. Two of these have general application. The Insurance Act gives private insurance companies a statutory right to health information and medical reports relating to any claims made on group or individual policies[163]. There is no statutory provision for employers to have access to that information, even if the claim is made on the employer's group policy. The Employment Standards Act, 1974 has general application, but deals only with the rights to maternity leave and not with other types of sick leave[164].

(b) Teachers--The Education Act, 1974 states that teachers are entitled to a minimum number of sick days, with pay, if a physician's or dentist's certificate documents their absence[165]. No provision is made regarding the form of certificate, or with respect to whether a diagnosis must be included (except in the cases of acutely inflamed mouth or communicable disease exposure)[166].

(c) Hospital Employees--Regulation 729 under The Public Hospitals Act states that hospital employees absent from work for 3 or more days as a result of illness must report to an

employee health-service nurse before returning to work[167]. No stipulation is made concerning what kind of examination is to be made of the employee[168]. No comparable provisions are contained in The Private Hospitals Act.

(d) Ontario Civil Servants--Regulations under The Public Service Act require all classified and unclassified staff to produce a medical certificate to qualify for sick leave with pay[169]. The form of certificate is not set out, nor is there any indication of whether a diagnosis is to be included. A unique provision is applicable to classified civil servants. The Deputy Minister may require an employee to submit to a medical examination if that employee is "for reasons of health...frequently absent or unable to perform his duties"[170].

(e) Confidentiality of Sick Leave Information--No obligations relating specifically to this type of information are contained in Ontario's statutes or regulations.

The Public Health Act and Employee Health Information. Clearly, it is imperative that the public health authorities have rights of access to the health records of employees who deal in any way with the public, or are in a position to endanger the public health as a result of being a carrier of, or having been exposed to, a communicable disease.

Inspectors may be appointed by the Minister of Health for purposes of any portion or all of The Public Health Act[171]. These inspectors are given a statutory right of access to all registered business premises to ensure compliance with the Act or regulations[172]. Obstructing an inspector is an offence[173], and provision is made for inspectors to obtain a judge's authorization for entry into any place (not only business premises) in order to investigate and inspect or make copies of any documents[174]. No exception is made for employees' health records.

The Minister of Health has a further statutory obligation to inspect all institutions caring for people, to ensure that The Public Health Act and regulations are complied with[175]. This would presumably include access to records to confirm that employees are free from communicable diseases[176].

Physicians and drugless practitioners have a general duty to report any confirmed or suspected cases of communicable diseases to the local medical officer of health[177]. Physicians and others retained by employers to provide health services to employees are subject to this duty to report.

Access to health records and information as contemplated in The Public Health Act does not require the consent of the person who is the subject of those records.

There is no requirement or authority for employers to be given the information generated under the Act or regulations. On the other hand, there are no provisions in The Public Health Act requiring health information to be kept secret or confidential.

Research and Statistical Use of Health Information

Introduction. In the course of its activities, the provincial government accumulates a great deal of health information. Much of this information may be the subject of statistical compilation and analysis, or form a basis for research, even if no specific statutory provision is made for these purposes. The statutory provisions that do exist are the subject of this section.

Specific references to research and statistical use of health data are found in 19 Ontario statutes or regulations. The Ministry of Health administers 11 of these[178]. The remaining 8 statutes are dealt with by other Ministries[179]. Only those Acts administered by the Ministry of Health will be dealt with here.

Locus of Responsibility. The legislation generally provides for formal control over statistical and research uses of health information. Some ministerial authority is required to initiate projects, or approve those initiated by others. The Minister of Health may be empowered to do these things, or they may be dealt with by regulations or agreements approved by the Lieutenant Governor in Council between holders of individuals' health records. Where no ministerial consent is required, the legislation includes specific directions for the use of aggregated information in which individuals may not be identified[180].

Minister of Health--General Powers. The Ministry of Health Act, 1972 gives the Minister extremely broad authority and discretion to collect and, if he or she so wishes, publish "such information and statistics...as are considered necessary or advisable" relevant to his or her duties and responsibilities as Minister of Health[181].

The Minister also has responsibility for the Ontario Health Insurance Plan. The Health Insurance Act, 1972 gives him or her

broad discretion to authorize surveys and research programmes and obtain statistics for purposes related to the Plan[182].

The remaining statutory authority for the Minister of Health to initiate surveys is to be found in The Public Health Act. He or she may cause periodic cancer surveys to be carried out and may require physicians and institutions to report every case of cancer as prescribed by the regulations under the Act[183]. There are, however, no such regulations. The Public Health Act also requires every local board of health to report weekly to the Ministry on deaths and instances of communicable diseases[184]. This requirement has the ultimate effect of a survey.

Specific research into the causes of any communicable disease may be commissioned by the Minister, according to The Public Health Act, and an appointee for these purposes has the powers to collect information as if he or she were a commissioner under The Public Inquiries Act, 1971[185].

Finally, the Minister may direct hospitals to ignore certain confidentiality provisions in The Public Hospitals Act, and require medical record information and x-ray films to be delivered to the Tuberculosis Prevention Service of the Ministry and to The Ontario Cancer Treatment and Research Foundation[186].

Statistics and Research by Foundations. The Ontario Cancer Treatment and Research Foundation and The Ontario Mental Health Foundation are statutory creatures with objects, among others, of conducting programmes of research and ensuring the adequate reporting of cases and compilation of data[187]. Foundations are empowered to make agreements with universities, medical associations, hospitals and other persons in the furtherance of these objects[188]. Both The Cancer Act and The Ontario Mental Health Foundation Act require that any such agreements be approved by the Lieutenant Governor in Council[189]. The institutions, again, subject to the approval of the Lieutenant Governor in Council, may make their own by-laws, rules and regulations[190].

Confidential information concerning cancer and mental health patients may be used for research and statistical work under The Cancer Act and The Mental Health Act and both these Acts explicitly dispense with any requirements for obtaining the consent of the patients[191].

Statistical and Research Use by Regulators of Health-Care Providers. With minor exceptions, the legislative scheme relating to the compilation, dissemination and use of statistical

data is the same for the following groups and their governing bodies:

- (a) dentists[192],
- (b) denture therapists[193],
- (c) physicians[194],
- (d) nurses[195],
- (e) optometrists[196],
- (f) pharmacists[197], and
- (g) funeral directors[198].

The statutory governing bodies of these professions and occupations are given authority to determine what information is to be compiled for statistical purposes, and to compel the production and collection of the information they require. All governing bodies may make regulations in this connection, subject to approval of the Lieutenant Governor in Council.

To ensure that their regulations are complied with, all governing bodies may make application for restraining orders against their members. In addition, failure to comply with the provisions of the Acts or regulations is deemed to be professional misconduct on the part of a member[199].

The information collected for statistical purposes probably falls within the scope of the wide confidentiality sections found in each of the Acts regulating the occupations of denture therapy, dentistry, medicine, optometry, pharmacy, and funeral directors[200]. The legislation regulating nurses does not contain a comparable section.

Patient Consent for Research and Statistical Use of Health Information. There are no provisions for obtaining the consent of patients for research and statistical uses of information relating to them.

Summary. The Minister of Health has legislative authority to initiate and conduct surveys, statistical compilations and research which may result in the collection of individually identifiable information.

The governing bodies of health-care providers and funeral directors have legislative authority to determine research and

statistical information requirements and may compel their members to provide individually identifiable information to meet these needs.

The statutory foundations have a relatively free hand in the area of research and statistical information handling, within the confines of their own governing statutes.

There are no provisions in the statutes administered by the Ministry of Health regarding the obtaining of a patient's or subject's consent for the use of his or her health information for research or statistical purposes.

Student Health Information—Elementary and Secondary Schools

The following groups may, at various stages, deal with student health information:

- (a) principals,
- (b) teachers,
- (c) school boards,
- (d) health-care providers employed by boards,
- (e) parents, guardians and pupils over the age of majority, and
- (f) local public health agencies, medical officers of health, public health nurses.

How these groups handle student information may be affected by The Education Act, 1974, The Health Disciplines Act, 1974, The Psychologists Registration Act and The Public Health Act or the regulations under them. For the purposes of this legislation, student health information may be divided into 3 distinct categories:

- (a) part of the permanent pupil record as defined in the regulations under The Education Act, 1974,
- (b) information kept temporarily with the permanent pupil record and forming part of the record for as long as it is kept there, and
- (c) health information generated as a result of the student's involvement with the school system, but not

forming part of the pupil record (e.g. public health records).

In general, it can be said that the information contained in the formal pupil record, even temporarily, is protected by statutory confidentiality provisions. Other health information in the hands of school authorities may not be protected.

Records of pupils now at school are the responsibility of school principals. Former pupils' records are held by the school boards. Student health information generated by the public health authorities is controlled by the local medical officers of health. Attempts to describe the legislative treatment of all this information become confused by some apparently inconsistent provisions in the legislation governing the various parties, particularly public health staff and other health-care providers.

Principals and Pupil Records. Primary responsibility for pupil records is vested in school principals[201]. Under The Education Act, 1974 the principal must establish, maintain, transfer and dispose of a record for each pupil enrolled[202].

The pupil record is comprised of a record folder (a printed form on which must be entered a comprehensive range of summarized information), achievement forms, other informational insertions approved by the principal, and an office index card[203].

The principal has considerable discretion concerning the contents of a record. Information which might facilitate emergency assistance to the pupil may be included. Health information presumably falls into this category. Referrals to services or agencies (e.g. mental health institutions) may be recorded on Part H of the record and additional information about such referrals may be inserted and kept with the record[204]. Any record entry concerning conviction of an offence or institutionalization for treatment of addiction, mental disorders or correction may be deleted by the principal. He or she may destroy all or part of the record after deletions of this sort. Similarly, other unspecified information or material may be removed from the record folder and either given to the subject or destroyed[205].

The principal's discretion about record content is limited in 2 important instances:

- (a) subject consent is necessary before the administration of an individual psychological assessment[206].

("Subject" includes a minor pupil's parent or guardian); and

(b) subject must be consulted before a summary of any recommendations regarding special health problems can be entered on Part E of the record folder and, by regulation, any such entries must be kept current[207].

Confidentiality of Principal Controlled Records. The pupil record is "privileged" for the information and use of supervisors, the principal and teachers for the improvement of the pupil's instruction; for the principal's use in preparing reports required by the Act and regulations or reports relating to the student's further education and employment; and for the compilation and delivery of information required by the school board or the Minister. The record is not admissible in evidence except to prove its existence and in discipline proceedings. No one may otherwise be required to give evidence concerning its contents[208].

Everyone who acquires knowledge of the record's content through his or her duties or employment, must keep such knowledge secret, except as required for his or her legitimate duties. Other than in this and the exceptions noted above, neither the record nor its contents are to be disclosed without the written permission of an adult pupil or the guardian of a minor pupil. This is a rare instance of informed consent, as the subject has access to the record[209].

The pupil record, or a true copy, may be transferred to a school outside the purview of The Education Act, 1974 only upon subject request for, or consent to, transfer, and written assurance from the recipient school's principal that the record will be maintained, transferred and disposed of according to the Act and regulations. The subject may obtain a copy of the pupil record where the principal is satisfied that it is required for education outside Ontario[210].

Teachers and Pupil Records. Teachers generate a great deal of the information contained in the official pupil record, and have access to the record for the purpose of improving the instruction of the pupil[211]. Information obtained by teachers from the record must be kept confidential[212]. It may be that information about such matters as absence from school because of sickness would not find its way into the formal record in the normal course of events, and that sort of information would not be subject to any statutory confidentiality, since only the

formal record is referred to in the confidentiality section of The Education Act, 1974.

School Boards and Pupil Records. The Education Act, 1974 and the regulations made thereunder state that the school boards must:

- (a) report annually to the Ministry of Education the names, ages and reasons for the non-enrolment of school age children, (relevant health reasons would be included in these reports[213]),
- (b) receive reports of infectious or communicable disease from principals[214],
- (c) retain records of former pupils for 70 years[215].

The Act also provides that school boards may:

- (a) provide minor surgical treatment for pupils, with parental consent[216],
- (b) have access to any information in pupil records[217].

School board members and staff are required to keep pupil record information confidential[218]. Health information obtained by the board which is not part of the pupil record is not protected by any statutory confidentiality requirement.

Psychiatrists, Psychologists Employed by Boards. School boards are given authority under The Education Act, 1974 to hire psychiatric and psychological professional staff[219] and such staff are to be under the "administrative authority" of the principal of the school[220].

Two types of student health information may come to the knowledge of a psychiatrist employed by a school board:

- (a) information from the school's pupil record,
- (b) information obtained by the psychiatrist in the course of examination and treatment.

It is clear that psychiatrists must keep confidential any health information obtained from the pupil record. A psychiatrist, like all other school board employees, must comply with the confidentiality provisions of The Education Act, 1974[221]. As a general rule, information obtained by a psychiatrist in the

course of examination or treatment of a student must not be communicated to third parties[222].

Whether a psychiatrist may keep information confidential from the school authorities is not clear from reading the statutes. As noted above, a psychiatrist is, by regulation, declared to be under the administrative authority of the principal. The regulations of The Education Act, 1974 and The Health Disciplines Act, 1974 appear to conflict. This conflict is similar to those encountered by physicians employed by private companies. Reconciliation of the statutory duty of confidentiality owed to the patient and the duties owed to the employer may not easily be accomplished. There is some judicial authority for the proposition that an employer cannot require an employed physician to disclose confidential information. These apparent conflicts are discussed in the section of the report dealing with employment related health information. It is enough to note here that this is a problem not directly addressed by the legislation concerning pupil records.

Psychologists, unlike psychiatrists, do not have their code of professional conduct set out in regulations under their governing statute. Psychologists are subject to disciplinary proceedings for unprofessional conduct, but it is not strictly accurate to say that they have a statutory duty of confidentiality regarding patient information. Given the employee status of psychologists working for a school board, and the fact that they are declared by regulation to be under the administrative authority of the principal, it is, at the present time, unclear whether psychologists are within their legal rights in refusing to give information about pupils to the school authorities[223].

Physicians, Nurses, Dentists Employed By Boards. Apparently no school boards in Ontario today employ these professional persons, although statutory provisions exist for their employment[224].

Pupil-Guardian and Pupil Records. In addition to his or her right to be consulted concerning the health summary information on the record[225] and the requirement of consent to psychological assessment[226], the subject is entitled to examine the record[227], to request the correction or removal of alleged inaccuracies[228], and to pursue any disagreement to a hearing before a person designated by the Minister[229]. Pending a resolution, the request and a note indicating the principal's reasons for non-compliance are placed in the record folder[230]. No action may be brought against any person concerning a record's content[231].

On leaving school, a subject may request and receive a copy of the scholastic record summary and the materials and information stored in the record folder. These insertions may contain health related information. If they are not requested by the subject, the insertions are to be destroyed[232].

Retention and Destruction of Pupil Records. The record folder, complete with its health related summaries, is to be retained by the board for 70 years, either at the school or at a central records office. An additional requirement is placed on private schools which, when they cease operation, are required to send their pupil records to the Minister forthwith[233].

Although regulations under The Education Act, 1974 provide that all or part of the pupil record is to be destroyed under certain circumstances[234], there is no mention of the method of destruction.

Pupil Health and Student Health Information. The local medical officer of health may become involved with student health information in 2 ways:

- (a) communicable diseases must be reported to the public health authorities by those in the school system[235], and
- (b) a school board may enter into an agreement directly with the local board of health to provide medical and dental inspection and public health nurse services for the pupils in the board's jurisdiction[236].

The local medical officer of health always controls the activities of public health nurses[237]. However, if a school board directly employed school medical officers and public health nurses, the public health nurses would be under the control of the board[238]. Control of the public health nurses presumably includes control over the health information which they generate in the course of their activities.

Confidentiality of Public Health-Student Information. No direct protection of the confidentiality of this type of information is provided for in either The Public Health Act or The Education Act, 1974. There are no confidentiality provisions at all in The Public Health Act, and the information generated by the public health authorities does not form part of the formal pupil record, with the result that the confidentiality provisions of The Education Act, 1974 are inapplicable.

Limited protection may be found elsewhere in legislation. There are essentially 3 situations where this may arise:

- (a) public health authorities divulging student health information to third parties generally,
- (b) public health authorities divulging information to school authorities, and
- (c) school authorities which have received this type of information from the public health authorities divulging it to third parties generally.

In the first situation, the regulation under The Health Disciplines Act, 1974 appears to prevent the medical officer of health from divulging information to third parties generally. He or she, as a physician, is bound to keep patient information confidential. Since public health nurses are placed under the authority of the medical officer of health, the nurses should maintain at least the same level of confidentiality.

In the second situation, it is unclear whether the public health authority is allowed to disclose student health data to school authorities. Both authorities have statutory duties and responsibilities regarding student health. The medical officer of health has a statutory obligation "to execute, do and provide all such acts, matters and things as are necessary" to protect the public health[239]. Transmitting student health information to schools may well fall within this duty. In addition, the medical officer of health is granted freedom from liability in "other proceedings" for acts done in good faith in the intended execution of his or her duty[240].

In the third situation, it seems reasonably clear that any information given to school authorities by the public health authorities is unprotected by statutory confidentiality unless that information is placed on the formal pupil record.

Health-care Institutions and Health Records

The Ministry of Health administers the statutes regulating the following types of institutions:

- (a) public hospitals,
- (b) mental health (psychiatric) facilities,
- (c) private hospitals,

- (d) mental hospitals,
- (e) community psychiatric hospitals,
- (f) private sanitaria,
- (g) nursing homes, and
- (h) homes for special care.

A confusing array of legislative requirements applies to these institutions. Some may be subject to 2 or more statutes or regulations, depending upon the types of health care provided. The various Acts and regulations differ radically in their treatment of patient records, as the charts on pages 86 and 87 indicate.

It will be observed from the comparison charts that the patient record is protected by confidentiality provisions in only 4 types of institution: public hospitals; mental health facilities; nursing homes and private sanitaria. Only patients in the first 3 types of institution have a limited option to consent to release of their records. This may be a means by which patients may indirectly gain access to their own health information. It should be borne in mind, however, that patient consent provisions do not enable the patient to compel disclosure of his or her record. Further, the legislation does not provide for informed consent, as the patient has no right of direct access to his or her record. Only under The Private Sanitaria Act has a former patient a right to limited information from his or her record.

Public hospitals are the most heavily regulated with relation to patient records. Under The Public Hospitals Act the medical record is the property of the hospital and is to be kept in the custody and safekeeping of the administrator. Regulation 729 defines the medical record by its extensive contents; provides for the intra-hospital transmission of reports (e.g. of radiological examinations and renal dialysis treatments) to the administrator for inclusion in the medical record; and requires only certain (but not all) hospital departments to retain their parts of the record for up to 5 years, after which they are to be disposed of by the administrator or the laboratory director. The regulation provides for long term retention of the complete medical record, and the method of storage and requires that destruction shall be carried out in accordance with Board approved practices. There are also provisions for mandatory release of the medical record to 5 categories of third parties,

							HOMES FOR SPECIAL CARE
							NURSING HOMES
							PRIVATE SANITARIA
CHART OF PATIENT RECORD PROVISIONS in Legislation administered by the Ministry of Health regulating HEALTH-CARE INSTITUTIONS							
endnote:	[241]	[242]	[243]	[244]	[245]	[246]	[247] [248]
Patient Records Generally.	X	X	X	-	X	X	X X
Confidentiality.	X	X	-	-	-	X	X -
Ownership--Possession.	X	-	-	-	-	-	X -
Safekeeping--Custody--Maintenance.	X	-	X	-	X	-	X X
Retention Generally.	X	-	-	-	-	-	X -
Method of Retention.	X	-	-	-	-	-	- -
Disposal Generally.	X	-	-	-	-	-	- -
Method of Disposal.	X	-	-	-	-	-	- -
Hospital Department Retention-Disposal.	X	-	-	-	X	-	- -
Internal Distribution of parts or copies of Record.	X	-	X	-	X	X	X -
Patient--Representative Consent to Disclosure.	X	X	-	-	-	-	X -
Direct Access by Patient.	-	-	-	-	-	-	- -
Limited Release to Former Patient.	-	-	-	-	-	X	- -
Limited Release to Inquirer of Board Member.	-	-	-	-	-	X	- -
Third Party Disclosure. (see Chart overleaf).	X	X	-	-	-	X	X -

		PATIENT RECORD--THIRD PARTY		DISCLOSURE PROVISIONS		HOMES FOR SPECIAL CARE	
		in Legislation administered by the		Ministry of Health regulating		NURSING HOMES	
		HEALTH-CARE INSTITUTIONS		PRIVATE SANITARIA		COMMUNITY PSYCH. HOSPITALS	
		MENTAL HEALTH FACILITIES	PUBLIC HOSPITALS	MENTAL HOSPITALS	PRIVATE HOSPITALS	MENTAL HOSPITALS	HOMES FOR SPECIAL CARE
M A N D A T O R Y	Courts.	[249]	[250]	[251]	[252]	[253]	[254]
	(Veto-Hearing-Record Return).	-	X	-	-	-	-
	Min. of Health Inspector.	X	-	-	-	-	X
	Coroner--representative.	X	-	-	-	-	X
	College Physicians & Surgeons.	X	-	-	-	-	-
	TB/Prevention Cancer Foundation.	X	-	-	-	-	-
	Supervisory Board of Visitors.	-	-	-	-	-	X
<u>WITH PATIENT CONSENT:</u>							
	Any person.	X	X	-	-	-	X
	Health-Care Provider treating Patient in health facility (no consent required if emergency).	-	X	-	-	-	-
<u>NO CONSENT REQUIRED:</u>							
D I S C R E T I O N A R Y	Attending Physician--Dentist-- Staff--Employee treating Patient.	X	X	-	-	-	X
	'Administrator'--Nurses.	-	X	-	-	-	X
	Medical staff for teaching--research.	X	-	-	-	-	-
	Person for research-- academics--statistics.	-	X	-	-	-	-
	Disclosure outside the facility to be non-identifiable.	-	X	-	-	-	-
	Ministry of Health, only for statistics--approved research.	X	-	-	-	-	-
	Administrator of another Hospital, on formal request.	X	-	-	-	-	-
	'Administrator' of a health facility current treating Patient, on formal request.	-	X	-	-	-	-
	Administrator of another Nursing Home to which Patient has transferred.	-	-	-	-	-	X
	Haematology Users' Data Bank.	X	-	-	-	-	-
	Veterans Affairs (Canada).	X	-	-	-	-	-

and discretionary release to 7 categories, 6 of the latter without patient consent.

The Mental Health Act, which regulates psychiatric facilities, does not deal with the content, safekeeping, retention, storage or destruction of the clinical record. However, the Act contains the most rigorous safeguards to protect the confidentiality of patient information. Only the courts may compel disclosure of this information and such disclosure must be determined to be essential for purposes of administration of justice. The attending physician may force an in camera hearing to determine whether, in fact, disclosure is justified. The record must be returned to the officer-in-charge of the psychiatric facility. The Mental Health Act also contains the most detailed provisions in the Ontario statutes concerning discretionary disclosure. Health-care providers directly involved with physical or mental treatment of a patient, whether inside or outside the psychiatric facility, may have access to patient information. Patient consent to this kind of release, outside the psychiatric facility, is normally required, but may be dispensed with in an emergency. In addition to those actually treating the patient, the administrator of a health facility where a patient is currently treated may, after making a written request, be given patient information by a psychiatric facility. Patient consent is not required for this type of release. Where the record is disclosed to a person outside the psychiatric facility for research, academic or statistical purposes, patient identification is first to be removed from the record, and the person receiving the record may only use it for the stated purposes and must not disclose the patient's identity in any way.

The patient record provisions of Regulation 196/72 under The Nursing Homes Act, 1972 are similar to, but not as extensive as, those pertaining to public hospital records. The resident's medical and drug records, which are defined by their contents, are not to be removed by any person other than a Ministry of Health inspector. However, the regulation provides for mandatory disclosure to the courts, a coroner for inquest or investigation purposes, and also provides for discretionary disclosure to a person who presents a written request signed by the resident. Discretionary disclosure may be made to the attending physician or dentist and to members of the nursing staff. The regulation also provides for automatic transfer of the record, without formal request or patient consent, when the resident moves to another nursing home. The provisions for long term retention of the record do not specify methods of storage or eventual destruction. The records of a nursing home which ceases to operate are to be delivered to the Ministry of Health.

In contrast, the confidentiality and security of the records of residents in nursing homes and approved homes licensed under The Homes for Special Care Act are not safeguarded.

The regulations under The Private Hospitals Act and The Community Psychiatric Hospitals Act contain only general requirements concerning the safekeeping, maintenance and some internal distribution of patient records, which are akin in descriptive content to the public hospital record. All 5 community psychiatric hospitals in Ontario are designated psychiatric facilities under The Mental Health Act; 4 of them are also public hospitals under The Public Hospitals Act and the fifth is also a children's mental health centre governed by The Children's Mental Health Services Act, 1978 which is administered by the Ministry of Community and Social Services.

The major concern of The Private Sanitarium Act as it relates to patient records is that information be made available to the members of the supervisory board of visitors. The board is to be kept informed of many aspects of a patient's detention by the transmission by the superintendent to the board secretary of, for example, copies of admission requisitions and medical certificates. The board may order copies of the clinical record produced "whenever they see fit". A board member may also direct the secretary to give limited information about a patient to a person who has applied to that board member to be informed whether that patient is detained in the sanitarium. As the only sanitarium currently licensed under this Act is also a designated psychiatric facility under The Mental Health Act, which contains stringent clinical record disclosure provisions, there is considerable potential for conflict.

The Mental Hospitals Act contains no provision relating to patient records. Mental hospitals, however, are subject to the detailed confidentiality provisions of The Mental Health Act.

In summary, the only thing that may be said with certainty about the treatment of health records held by health-care institutions in Ontario is that there is no consistency in the province's legislation.

ENDNOTES

1. The Ambulance Act; The Cancer Act; The Cancer Remedies Act; The Community Psychiatric Hospitals Act; The Denture Therapists Act, 1974; The Drugless Practitioners Act; The Funeral Services Act, 1976; The Health Disciplines Act, 1974; The Health Insurance Act, 1972; The Homes for Special Care Act; The Mental Health Act; The Mental Hospitals Act; The Ministry of Health Act, 1972; The Nursing Homes Act, 1972; The Ontario Mental Health Foundation Act; The Private Hospitals Act; The Private Sanitarium Act; The Psychologists Registration Act; The Public Health Act; The Public Hospitals Act; The Sanatoria for Consumptives Act; The Venereal Diseases Prevention Act.
2. Sections 9(3)(c) & 10 of Regulation 85 under The Charitable Institutions Act.
3. See Employment Related Health Information, p.68.
4. ss.27-36 of Regulation 689 under The Private Hospitals Act.
5. 37 pieces of legislation deal with the reporting of data. See the section of the report on Mandatory Reporting of Health Information for consideration of some of these provisions.
6. See Retention, Storage and Disposal of Health Records, p.66.
7. s.43 of Regulation 729 under The Public Hospitals Act.
8. See Appendix II of the report, Confidentiality Provisions in Ontario Legislation.
9. The Ambulance Act, s.18(3).
10. e.g. The Health Disciplines Act, 1974, ss.40, 64, 110 & 136; The Denture Therapists Act, 1974, s.21; The Ambulance Act, ss.18(1),(2); s.11 of Regulation 228, s.35 of Regulation 230, s.9 of Regulation 231, s.9 of Regulation 232 & s.11 of Regulation 233 under The Drugless Practitioners Act.
11. e.g. The Private Hospitals Act, s.11; The Public Hospitals Act, s.15 and s.10 of Regulation 729 under the Act; s.12

of Regulation 94 under The Community Psychiatric Hospitals Act; The Mental Health Act, s.4.

12. The Child Welfare Act, 1978, s.2.
13. The Day Nurseries Act, 1978, s.16(4).
14. The Homes for the Aged and Rest Homes Act, s.20.
15. e.g. The Nursing Homes Act, 1972, s.16 and s.91(2)(b) of Regulation 196/72 under the Act.
16. e.g. The Children's Residential Services Act, 1978, s.14(3).
17. The Education Act, 1974, s.15(6).
18. e.g. The Employment Standards Act, 1974, s.45.
19. The Audit Act, 1977, s.13.
20. The Venereal Diseases Prevention Act, ss.3 & 7.
21. A full discussion of this subject is found in the section of the report on Mandatory Reporting of Health Information.
22. The Occupational Health and Safety Act, 1978, s.37(1).
23. The Highway Traffic Act, s.152.
24. The Venereal Diseases Prevention Act, ss.10(3) & 12.
25. The Vital Statistics Act, s.50(1).
26. The Health Insurance Act, 1972, s.33.
27. e.g. The Education Act, 1974, ss.34, 146.14, 75 & 230(k),(1),(m); ss.17(c),(d), & 18(m),(p) of Regulation 555/79 under the Act.
28. e.g. The Family Benefits Act, s.10b(c), ss.11(2)4a,5, 25b(2) & Form 1 of Regulation 287 under the Act; The General Welfare Assistance Act, s.8; ss.12(4) & 16(2) of Regulation 821 under The Vocational Rehabilitation Services Act.
29. The Workmen's Compensation Act, ss.52 & 117.

30. The Highway Traffic Act, ss.143 & 144.
31. The Income Tax Act, S.C. 1970-71-72, c. 63, ss.29 & 30(1)(c), as included by reference in The Income Tax Act, ss.3(4)(a),(d).
32. The Occupational Health and Safety Act, 1978, ss.15(1)(d),(h), 25(1), 26 & 27.
33. The Public Health Act, s.84(5).
34. The Health Disciplines Act, 1974, ss.40, 64, 110 & 136.
35. The Insurance Act, s.157.
36. The Consumer Reporting Act, 1973, ss.1(j) & 8(1),(3).
37. Police officers and private investigators are isolated exceptions to this general pattern.
38. s.36(29) of Regulation 576/75 under The Health Disciplines Act, 1974.
39. s.26.21 of Regulation 577/75 under The Health Disciplines Act, 1974.
40. s.26.21 of Regulation 585/75 under The Health Disciplines Act, 1974.
41. s.7.26 of Regulation 42/75 under The Denture Therapists Act, 1974.
42. s.21(k) of Regulation 578/75 under The Health Disciplines Act, 1974.
43. s.10 of Regulation 698 under The Psychologists Registration Act.
44. A major exception to this is found in The Venereal Diseases Prevention Act, ss.13(1) & 14, which require secrecy of "every person" who is in any way involved with related information. See also ss.15 & 18(2) of the Act.
45. The Ambulance Act, s.18(3); The Consumer Reporting Act, 1973, s.18(1); The Denture Therapists Act, 1974, s.22(1); The Funeral Services Act, 1976, s.32(1); s.9 of Regulation 383 under The General Welfare Assistance Act; The Health Disciplines Act, 1974, ss.41(1), 65(1), 111(1) & 137(1); The Health Insurance Act, 1972, s.44(1); The Income Tax

Act, s.44(1); The Liquor Licence Act, 1975, s.25(1); The Ministry of Correctional Services Act, 1978, s.10; The Ontario Guaranteed Annual Income Act, 1974, s.10(1); The Private Investigators and Security Guards Act, s.13; The Venereal Diseases Prevention Act, s.14; The Vital Statistics Act, s.48; The Workmen's Compensation Act, s.98(1).

46. The Consumer Reporting Act, 1973, s.8(1); s.7.26 of Regulation 42/75 under The Denture Therapists Act, 1974; s.36(29) of Regulation 576/75; s.26.21 of Regulation 577/75; s.21(k) of Regulation 578/75 & s.26.21 of Regulation 585/75 all made under The Health Disciplines Act, 1974; The Private Investigators and Security Guards Act, s.24; The Venereal Diseases Prevention Act, ss.13(1), 15 & 18(2);
47. The Consumer Reporting Act, 1973, s.8(1); The Health Insurance Act, 1972, s.44(1); The Ontario Guaranteed Annual Income Act, 1974, s.10(1).
48. Exceptions: administration of that Part of the Act; OHIP purposes; disclosure to employee's counsel; with subject consent; The Health Disciplines Act, 1974, s.65(1).
49. The Child Welfare Act, 1978, s.52(4).
50. Form 1 of Regulation 821 under The Vocational Rehabilitation Services Act.
51. The Public Services Act, s.10(1).
52. The Audit Act, 1977, s.21(1),(2); The Ministry of Treasury and Economics Act, 1978, s.15; The Ombudsman Act, 1975, s.13(1); The Private Sanitaria Act, ss.3(6),(10); The Statistics Act, s.4(1); s.66 of Regulation 820 under The Vital Statistics Act.
53. The Audit Act, 1977, s.21(4).
54. The Homes for the Aged and Rest Homes Act; The Mental Health Act; The Nursing Homes Act, 1972; The Private Sanitaria Act; The Public Hospitals Act; The Training Schools Act.
55. The Charitable Institutions Act; The Child Welfare Act, 1978; The Children's Institutions Act, 1978; The Children's Mental Health Services Act, 1978; The Children's Residential Services Act, 1978; The Community

Psychiatric Hospitals Act; The Day Nurseries Act, 1978;
The Developmental Services Act, 1974; The Homes for
Special Care Act; The Homes for Retarded Persons Act; The
Mental Hospitals Act; The Ontario Mental Health Foundation
Act; The Private Hospitals Act; The Sanatoria for
Consumptives Act.

56. See charts, pp.86 & 87.
57. ss.48(2),(3),(4),(5),(a)(b)(c),(d),(e),(f),(8),(7) of Regulation 729 under The Public Hospitals Act.
58. ss.91(2),(3),(4) of Regulation 196/72 under The Nursing Homes Act, 1972.
59. See list of designated psychiatric facilities in R.R.O. 1970, Regulation 576 as amended to Regulation 739/79 under The Mental Health Act.
60. Respectively, s.5 of Regulation 439 under The Homes for the Aged and Rest Homes Act and s.4 of Regulation 384/79 under The Training Schools Act.
61. The Private Sanitaria Act, s.3(6).
62. The Venereal Diseases Prevention Act, ss.13(1),(2), 14, 15 & 18.
63. The Health Insurance Act, 1972, s.33.
64. The Health Services Insurance Act, 1968-69, S.O. 1968-69, c.43, ss.22 & 24.
65. The Health Insurance Act, 1972, s.46.
66. ss.7, 8(2), 11(2), 12, 18(2), 28(1),(2),(3), 57 & 58 of Regulation 323/72 under The Health Insurance Act, 1972.
67. Ibid. ss.43(1),(1a),(2).
68. Ibid. ss.49(3) & 50.
69. Ibid. s.44(1).
70. Ibid. s.50.
71. The Health Services Insurance Act, 1968-69, S.O. 1968-69, c.43, s.23(2).

72. The Health Services Insurance Amendment Act, 1971, S.O. 1971, c.85, s.6(1).
73. The Health Service Insurance Act, 1968-69, S.O. 1968-69, c.43, s.23(5).
74. The Hospital Services Commission Act, 1956, S.O. 1956, c.31, ss.21 & 22 as enacted by S.O. 1960, c.47, s.2.
75. Ibid.
76. s.21 of Regulation 239, R.R.O. 1960 under The Hospital Services Commission Act, R.S.O. 1960, c.176.
77. See Collection of Health Information by Government, p.53.
78. s.66 of Regulation 820 under The Vital Statistics Act.
79. The Statistics Act, s.6.(1).
80. s.48(5)(e) of Regulation 729 under The Public Hospitals Act.
81. The Child Welfare Act, 1978, s.90.
82. The Income Tax Act, s.44(2).
83. The Ontario Guaranteed Annual Income Act, 1974, s.10(2).
84. The Cancer Act; The Cancer Remedies Act; The Denture Therapists Act, 1974, and Regulation 42/75 thereunder; The Funeral Services Act, 1976; The Health Disciplines Act, 1974 and Regulation 576/75, Regulation 577/75, Regulation 578/75 & Regulation 585/75 thereunder; The Health Insurance Act, 1972; The Mental Health Act; The Ministry of Health Act, 1972; The Ontario Mental Health Foundation Act; The Public Health Act and Regulation 729 under The Public Hospitals Act.
85. The Archives Act; The Child Welfare Act, 1978; The Education Act, 1974; The Highway Traffic Act; The Ministry of Correctional Services Act, 1978; The Occupational Health and Safety Act, 1978; The Statistics Act; The Vital Statistics Act; and regulations made under some of these Acts.

86. A more detailed look at this area is provided at p.75, Research and Statistical Use of Health Information.
87. The Statistics Act, ss.2(1)(a) & 6(1).
88. In certain circumstances, The Coroners Act, 1972, s.9, requires the reporting of deaths to the police or the coroner; and The Health Insurance Act, 1972, s.44(2)(a) gives a discretion to release a limited amount of information for purposes of administration of the Criminal Code (Canada).
89. Search warrants may be obtained under the Criminal Code, R.S.C. 1970, c. C-34, s.443, and under the provisions of The Provincial Offences Act, 1979, s.142.
90. s.26.26 of Regulation 577/75 & s.36(30) of Regulation 576/75 under The Health Disciplines Act, 1974.
91. The only specific right of access is found in The Health Disciplines Act, 1974, s.156(1) whereby the patient (or his or her agent) is entitled to have a marked copy of his or her pharmacy prescription, unless the prescriber directs otherwise.
92. The Health Insurance Act, 1972, s.44(2)(d).
93. The Education Act, 1974, s.231(3) and s.13(2) of Regulation 38/73 under the Act.
94. The Private Sanitaria Act, s.27.
95. The Child Welfare Act, 1978, ss.52(8) & 29(2)(a),(3).
96. The Occupational Health and Safety Act, 1978, s.15(1)(d).
97. In this section, "third parties" does not include persons or agencies involved in the administration of statutes (e.g. civil servants, occupational health and safety committees) or persons with statutory duties to collect information, (e.g. employers).
98. The Child Welfare Act, 1978, s.29(2)(c) entitles a parent appearing at a hearing held to determine if a child is in need of protection, to a copy of any court ordered medical or psychological assessment of a person who has been, or may be in charge of the child. [Cont'd over]

The Coroners Act, 1972, s.16(2) gives families of deceased persons access to coroner medical reports, if no inquest is held.

The Health Disciplines Act, 1974, s.8 requires Registrars of Colleges to send a copy of the complaints committee's decision and reasons therefor, to the complainant.

The Vital Statistics Act, s.43, gives third parties the right to know if a birth, still-birth, adoption, baptism, change of name, marriage or death has been registered, but no details of registration.

99. The Ambulance Act, s.18(3)(a),(c); The Audit Act, 1977, s.27(2); The Consumer Reporting Act, 1973, ss.8(1)(b), 18(1)(a),(c); The Denture Therapists Act, 1974, s.22(1)(a),(c); The Education Act, 1974, s.231(2),(6),(10); The Funeral Services Act, 1976, s.32(1)(a),(c); The Health Disciplines Act, 1974, ss.41(1)(a),(b),(d), 65(1)(a),(b),(d), 111(1)(a),(b),(d), 137(1)(a),(b),(d); The Health Insurance Act, 1972, s.44(2); The Liquor Licence Act, 1975, s.25 (1)(a),(c); The Ministry of Correctional Services Act, 1978, s.10; The Private Investigators and Security Guards Act, s.13; The Ombudsman Act, 1975, ss.13(2), 20(4); The Ontario Guaranteed Annual Income Act, 1974, s.10(2),(4); The Public Trustee Act, s.18; The Statistics Act, ss.4(2), 9(1); The Workmen's Compensation Act, s.98(1).
100. The Child Welfare Act, 1978, s.52(6),(7),(9); The Energy Act, 1971, s.6(3); The Occupational Health and Safety Act, 1978, s.34(8); The Mental Health Act, s.31(8); The Vital Statistics Act, s.43(2).
101. A person may also refuse to give evidence if it can be demonstrated that the evidence falls within a very narrow range of information which is "privileged". The doctor-patient relationship is not one which gives rise to a privilege.
102. The Consumer Reporting Act, 1973, s.18(2); The Denture Therapists Act, 1974, ss.22(2); The Education Act, 1974, s.231(2),(9); The Employment Standards Act, 1974, s.45(3),(4); The Energy Act, 1971, s.6(2); The Funeral Services Act, 1976, s.32(2); The Health Disciplines Act, 1974, ss.41(2), 65(2), 111(2), 137(2); The Insurance Act, s.90; The Liquor Licence Act, 1975, s.25(2); The Occupational Health and Safety Act, 1978, s.34(2); The Ombudsman Act, 1975, ss.20(6), 25(2); The Ontario Guaranteed Annual Income Act, 1974, s.10(3); The Workmen's Compensation Act, ss.81a(1),(2), 99.

103. A unique provision in The Mental Health Act, s.26a(6),(7), (8), allows a physician to object to production of psychiatric records in court and a special hearing may result to settle the issue. On the other hand, some confidentiality provisions may be overridden by s.50 of The Child Welfare Act, 1978, and s.26 of The Family Law Reform Act, 1978, which allow access by court order to otherwise confidential information relevant to a child abuse investigation or to the whereabouts of a respondent in a support action.

104. Regulation 599/75 under The Ambulance Act; The Children's Residential Services Act, 1978; Regulation 38/73 under The Education Act, 1974; The Employment Standards Act, 1974; The Health Disciplines Act, 1974 and Regulation 576/75, Regulation 577/75, Regulation 585/75 & Regulation 579/75 thereunder; Regulation 323/72 under The Health Insurance Act, 1972; The Income Tax Act; Regulation 578 under The Mental Hospitals Act; Regulation 196/72 under The Nursing Homes Act, 1972; Regulation 658/79, Regulation 659/79 & Regulation 660/79 under The Occupational Health and Safety Act, 1978; Regulation 729 under The Public Hospitals Act.

105. See p.83, Student Health Information, Retention and Destruction of Pupil Records for fuller details.

106. ss.33(1), 28 & 33(2),(3) of Regulation 38/73 under The Education Act, 1974.

107. ss.35a(2), 37(1b), 46(3), 47(2) & 47a of Regulation 729 under The Public Hospitals Act.

108. e.g. ibid. ss.47(2)(c),(a) & 35a(2).

109. e.g. ibid. ss.44(b),(a) & 42(3).

110. Ibid. s.42(1).

111. Ibid. ss.42(2),(3) & 43.

112. e.g. ibid. ss.36, 37(1), 46 & 51.

113. Ibid. ss.35a(2),(3), & 47a.

114. s.86 of Regulation 196/72 under The Nursing Homes Act, 1972.

115. The Health Disciplines Act, 1974, s.155(2) and ss.37 & 42 of Regulation 576/75, ss.28 & 33 of Regulation 577/75, s.36 of Regulation 585/75 & s.66 of Regulation 579/75 thereunder.

116. The Health Disciplines Act, 1974, s.156 and s.77 of Regulation 579/75 thereunder.

117. s.31(4) of Regulation 599/75 under The Ambulance Act; The Employment Standards Act, 1974, s.11(1)(a)(viii); s.20 of Regulation 323/72 under The Health Insurance Act, 1972; ss.19(2),(3) of Regulation 578 under The Mental Hospitals Act; ss.5(3) & 6 of Regulation 658/79, ss.9 & 10(3) of Regulation 659/79, ss.20(3), 67, 230(3) & 275 of Regulation 660/79 under The Occupational Health and Safety Act, 1978; s.67(2) of Regulation 729 under The Public Hospitals Act.

118. s.20 of Regulation 323/72 under The Health Insurance Act, 1972.

119. s.31(4) of Regulation 599/75 under The Ambulance Act.

120. The Health Disciplines Act, 1974, ss.40(3), 64(3), 110(3) & 136(3); The Private Investigators and Security Guards Act, s.17(3).

121. The Income Tax Act, s.35(3).

122. s.68 of Regulation 599/75 under The Ambulance Act; The Children's Residential Services Act, 1978, s.13(3); s.33(4) of Regulation 38/73 under The Education Act, 1974; s.251(2) of Regulation 659/79 under The Occupational Health and Safety Act, 1978; The Nursing Homes Act, 1972, s.12 and s.83 of Regulation 196/72 thereunder.

123. The Archives Act, s.3.

124. Ibid. s.6. Interviews with Government officials indicated that compliance with these sections is erratic, at best.

125. s.90 of Regulation 196/72 under The Nursing Homes Act, 1972.

126. The Occupational Health and Safety Act, 1978, s.34(1)(d).

127. s.70(2) of Regulation 729 under The Public Hospitals Act.

128. See Duties of Health-Care Professionals, p.55.

129. See Duties of Administrators, Inspectors, p.56.

130. s.61(k) of Regulation 729 under The Public Hospitals Act.

131. ss.27 & 28 of Regulation 689 under The Private Hospitals Act.

132. The Occupational Health and Safety Act, 1978, ss.3(1) & 1.29.

133. Ibid. ss.3(2),(3), 7(2), 8(3), & 41(2)3.,4.

134. Ibid. ss.3(2) & 8(3).

135. Ibid. s.1.8.

136. Ibid. ss.1.29 & 2(1).

137. Ibid. s.1.28.

138. Ibid. s.41.

139. Ibid. ss.7(3), 8(7), & 41(2)22.

140. Ibid. ss.7(8) & 8(9).

141. Ibid. ss.15(1)(a),(h).

142. Ibid. s.17(1)(e).

143. Ibid. s.15(1)(f).

144. Ibid. s.15(1)(d).

145. Ibid. ss.25(1) & 26(1),(2).

146. Ibid. s.25(1).

147. Ibid. ss.28(1)(c),(d).

148. Ibid. ss.33(1),(2),(3).

149. Ibid. s.10.

150. Ibid. s.11.

151. The Occupational Health and Safety Act, 1978, s.34(1)(d).
152. Ibid. s.34(3).
153. Ibid. s.37(1).
154. Ison, Terence G. Information Access and The Workmen's Compensation Board. Toronto : January, 1979. (Ontario Commission on Freedom of Information and Individual Privacy Research Publication; No.4.)
155. The Workmen's Compensation Act, ss.20 & 117.
156. Ibid. s.31.
157. ss.19(1),(2),(4), of Regulation 578 under The Mental Hospitals Act; ss.31(1),(2) & 35 of Regulation 689 under The Private Hospitals Act; ss.66(a),(b) & 67(1) of Regulation 729 under The Public Hospitals Act.
158. The Workmen's Compensation Act, s.52.
159. Ibid. s.80.
160. Ibid. s.98. Penalty for breach of this section - maximum fine, \$50.
161. Ibid. s.99.
162. Ibid. ss.21 & 22.
163. The Insurance Act, s.249.
164. The Employment Standards Act, 1974, s.36.
165. The Education Act, 1974, s.225(2).
166. Ibid. ss.225(2),(4), 229(1)(i) & 230(1).
167. s.61a(5) of Regulation 729 under The Public Hospitals Act.
168. The sole exception is ibid. s.61a(7), employees handling food must have a stool examination if absent because of a gastrointestinal disorder.
169. ss.74, 101 & 109 of Regulation 749 under The Public Service Act.

170. s.74(3) of Regulation 749 under The Public Service Act.

171. The Public Health Act, s.2a(1).

172. Ibid. s.2b(1).

173. Ibid. s.2b(6).

174. Ibid. s.2b(2).

175. Ibid. s.4(g).

176. e.g. as required by ss.46 & 47 of Regulation 972/75 (workers in food premises) under The Public Health Act.

177. The Public Health Act, s.64.

178. Supra, note 84.

179. Supra, note 85.

180. The Health Insurance Act, 1972, s.44(3); The Mental Health Act, s.26a(4).

181. The Ministry of Health Act, 1972, s.6(2)(d).

182. The Health Insurance Act, 1972, s.2(2)(e).

183. The Public Health Act, s.59.

184. Ibid. s.24.

185. Ibid. s.5(1).

186. s.48(8) of Regulation 729 under The Public Hospitals Act.

187. The Cancer Act, s.5; The Ontario Mental Health Foundation Act, s.5.

188. Ibid. s.6 of both statutes.

189. Ibid.

190. Ibid. s.8 of both statutes.

191. The Cancer Act, s.6a; The Mental Health Act, s.26a(3)(f).

192. The Health Disciplines Act, 1974, ss.25(r), 41(1),(2) & 42(1) and s.36(1) of Regulation 576/75 thereunder.

193. The Denture Therapists Act, 1974, ss.23(1)(1), 22(1),(2) & 25(1) and ss.7.10 & 11 of Regulation 42/75 thereunder.

194. The Health Disciplines Act, 1974, ss.50(s), 65(1),(2) & 66(1) and ss.23(1),(2) & 26.2 of Regulation 577/75 thereunder.

195. The Health Disciplines Act, 1974, ss.74(k) & 88(1) and s.21(a) of Regulation 578/75 thereunder.

196. The Health Disciplines Act, 1974, ss.96(p), 111(1),(2) & 112(1) and ss.31, 32, 33 & 26.31 of Regulation 585/75 thereunder.

197. The Health Disciplines Act, 1974, ss.122(1)(r), 137(1),(2), 162(1), 165(2) & 166.

198. The Funeral Services Act, 1976, ss.33(1)(o), 32(1),(2), 35(1) & 38(3,(4)).

199. Funeral directors and pharmacists are exceptions: non-compliance with the Act or regulations is a summary conviction offence (now a "provincial offence")--fines up to \$2,000 for individuals, and for corporations under The Funeral Services Act, 1976, up to \$25,000.

200. These confidentiality sections are similar to the following section taken from that Part of The Health Disciplines Act, 1974 which regulates the practice of medicine:

65.-(1) Every person employed in the administration of this Part, including any person making an inquiry or investigation under section 64, and any member of the Council or a Committee, shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry or investigation under section 64 and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Part and the regulations and by-laws or any proceedings under this Part or the regulations; or
- (b) as may be required for the enforcement of The Health Insurance Act, 1972;
- (c) to his counsel; or

(d) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Part or the regulations or by-laws.

[Note: s.64 refers to the investigation of members by the Registrar.]

201. According to ss.230(j),(k),(l) of The Education Act, 1974, principals must also give assiduous attention to the health of pupils; report communicable diseases to the health and education authorities; and refuse suspected carriers admission unless medical certification is obtained.
202. Ibid. s.230(d).
203. s.2 & Form 1 of Regulation 38/73 under The Education Act, 1974.
204. Ibid. ss.6(2)(d) & 16.
205. Ibid. s.29.
206. s.12(2)(s) of Regulation 704/77 under The Education Act, 1974.
207. s.13(3) of Regulation 38/73 under The Education Act, 1974.
208. The Education Act, 1974, ss.231(2)(b),(6)(a)(b),(7),(9), (13).
209. Ibid. ss.231(10),(11),(2),(3).
210. ss.28(3),(4),(5),(6) of Regulation 38/73 under The Education Act, 1974.
211. The Education Act, 1974, s.231(2).
212. Ibid. s.231(10).
213. Ibid. s.146.14 & e.g. s.34(a) of Regulation 704/78 thereunder.

214. The Education Act, 1974, s.230(k).

215. s.33(1) of Regulation 38/73 under The Education Act, 1974.

216. The Education Act, 1974, s.147(1)23.

217. Ibid. s.231(7).

218. Ibid. s.231(10).

219. Ibid. s.147(1)5.

220. s.23 of Regulation 704/78 under The Education Act, 1974.

221. The Education Act, 1974, s.231(10).

222. s.26.21 of Regulation 577/75 under The Health Disciplines Act, 1974.

223. s.10 of Regulation 689 under The Psychologists Registration Act.

224. The Public Health Act, ss.99 & 100.

225. s.13(2) of Regulation 38/73 under The Education Act, 1974.

226. s.12(2)(s) of Regulation 704/78 under The Education Act, 1974.

227. The Education Act, 1974, s.231(3).

228. Ibid. s.231(4).

229. Ibid. s.231(5).

230. s.27 of Regulation 38/73 under The Education Act, 1974.

231. The Education Act, 1974, s.231(8).

232. s.31 of Regulation 38/73 under The Education Act, 1974.

233. Ibid. s.33.

234. Ibid. ss.5(2), 29, 31, 32 & 33(3).

235. The Public Health Act, ss.83(3),(4),(5); The Education Act, 1974, s.230(k).

236. The Public Health Act, s.99.

237. The Public Health Act, s.35(7).

238. Ibid. s.100(1). Under s.100(2) if a school board employs only public health nurses and no school medical officer, control of the nurses is vested in the medical officer of health.

239. Ibid. ss.27 & 41.

240. Ibid. s.42(1).

241. Public Hospitals

Patient Records Gen.: ss.17(1), 20(2), 36, 37(1),(2), 38, 45(1), 46(1), 47(1), 50, 51, 52, 54(1) & 59(1) of Regulation 729 under The Public Hospitals Act.

Confidentiality: Ibid. s.48(1).

Ownership: The Public Hospitals Act, s.11.

Custody-Safekeeping: Ibid. s.11, & s.39(2) of Regulation 729 under The Public Hospitals Act.

Retention Generally: Ibid. ss.17(3), 42(2),(3), 44, 45(2) & 46.

Method of Retention: Ibid. s.42(1).

Disposal Generally: Ibid. ss.17(2), 42(2), 44, 45(1), 46(3) & 47(3).

Method of Destruction: Ibid. s.43.

Hospital Department

Retention-Disposal: Ibid. ss.35a(2),(3), 37(1a),(1b), 46(3), 47(1),(2) & 47a.

Internal Distribution: Ibid. ss.35(4), 35a(1), 36(1)(a), 37(1b), 39(1), 40, 41, 46, 47(1), 47a, 50(3), 51(3), 53(b), 54(2) & 59(1)(d).

Patient Consent: Ibid. s.48(5)(c).

Third Party

Disclosure: Ibid. ss.48(2),(3),(4),(5),(6),(7), (8).

242. Mental Health Facilities

Patient Records Gen.: The Mental Health Act, s.26a(1).

Confidentiality: Ibid. ss.26a(2),(9).

Patient Consent: Ibid. ss.26a(3)(a),(b) & (9)(a),(b).

Third Party

Disclosure: Ibid. ss.26a(3),(c),(d),(e),(f), (4)(a),(b),(5),(6),(7), (8),(9)(c).

243. Private Hospitals

Patient Records Gen.: ss.7, 8, 9, 22(4) of Regulation 689 under The Private Hospitals Act.
Safekeeping: Ibid. s.10.
Internal Distribution: Ibid. ss.11(2), 13, 14 & 15.

244. Mental Hospitals - The Mental Hospitals Act contains no patient record provisions.

245. Community Psychiatric Hospitals

Patient Records Gen.: ss.13, 14, 19, 20, 21 & 25(c) of Regulation 94 under The Community Psychiatric Hospitals Act.
Safekeeping: Ibid. s.22(2).
Hospital Department
Retention: Ibid. s.25(c).
Internal Distribution: Ibid. ss.22(1), 23 & 24.

246. Private Sanitaria

Patient Records Gen.: The Private Sanitaria Act, ss.13(2),(3), 20(1), 21(1), 22, 25, 29(1), 32, 38(3) & 54(1).
Confidentiality: ss.3(6),(10).
Internal Distribution: ss.20(4), 23, 24, 25, 26, 29(2), 31, 33 & 38(3).
Release to Former Patient: s.27.
Release to Inquirer: s.42.
Third Party Disclosure: ss.20(4), 23, 24(1),(4), 25, 26, 29(2), 31(1),(4)(a),(b),(c),(e), 33(1) & 38(3).

247. Nursing Homes

Patient Records Gen.: ss.44(2), 62, 65(3), 84, 85, 87(a) & 89 of Regulation 196/72 under The Nursing Homes Act, 1972.
Confidentiality: Ibid. ss.90(a) & 91(1).
Possession-Control: The Nursing Homes Act, 1972, s.12(3).
Maintenance: ss.84, 87 & 89 of Regulation 196/72 under The Nursing Homes Act, 1972.
Retention Generally: Ibid. s.86.
Internal Distribution: Ibid. ss.46(2)(b),(c),(3)(b), 59(2), 74(3),(4) & 85(c).
Patient Consent: Ibid. s.91(4)(d).
Third Party Disclosure: Ibid. ss.91(2),(3),(4).

248. Homes for Special Care
Patient Records Gen.: ss.7(c), 21(a) & 35 of Regulation
438 under The Homes for Special
Care Act.
Maintenance: Ibid. ss.7(a)(iii),(c) & 35.

249. Public Hospitals
ss.48(2)(a), 48(2)(b), 48(3), 48(4), 48(8), 48(5)(c),
48(5)(a), 48(5)(d), 48(5)(f),(6), 48(5)(b), 48(7) &
48(5)(e) of Regulation 729 under The Public Hospitals
Act.

250. Mental Health Facilities
The Mental Health Act, ss.26a(5), 26a(6),(7),(9)(c),(8),
26a(3)(a),(b),(9)(a),(b),
26a(3)(e), 26a(3)(c), 26a(3),
26a(3)(f), 26a(4)(a),(b) &
26a(3)(d).

251. Private Hospitals
The Private Hospitals Act and regulations thereunder
contain no third party disclosure provisions.

252. Mental Hospitals
The Mental Hospitals Act and regulations thereunder contain
no patient record provisions.

253. Community Psychiatric Hospitals
The Community Psychiatric Hospitals Act and regulations
thereunder contain no third party disclosure provisions.

254. Private Sanitaria
The Private Sanitaria Act, ss.20(4), 23, 24(1),(4), 25,
26(1), 29(2),
31(1),(4)(a),(b),(c),(e),
33(1) & 38(3).

255. Nursing Homes
ss.91(2)(a), 91(2)(b), 91(3), 91(4)(d), 91(4)(a), 91(4)(b)
& 91 (4)(c) of Regulation 196/72 under The Nursing Homes
Act, 1972.

256. Homes for Special Care
The Homes for Special Care Act and regulations thereunder
contain no third party disclosure provisions.

SCHEDULE OF STATUTES AND REGULATIONS

The Ambulance Act, R.S.O. 1970, c.20, as am. S.O. 1971, Vol.2, c.50; S.O. 1972, c.93, & S.O. 1975, c.84.
O. Reg. 599/75 as am. O. Reg. 796/75 & O. Reg. 560/77.

The Anatomy Act, R.S.O. 1970, c.21.
R.R.O. 1970, Regulation 18 as am. O. Reg. 772/73.

The Archives Act, R.S.O. 1970, c.28.

The Audit Act, 1977, S.O. 1977, c.61.

The Blind Persons' Rights Act, 1976, S.O. 1976, c.14.

The Cancer Act, R.S.O. 1970, c.55, as am. S.O. 1972, c.34.

The Cancer Remedies Act, R.S.O. 1970, c.56.

The Charitable Institutions Act, R.S.O. 1970, c.62, as am. S.O. 1971, Vol.2, c.50; S.O. 1972, c.61, & S.O. 1973, c.24.

R.R.O. 1970, Regulation 85 as am. O. Reg. 713/73;
O. Reg. 387/76; O. Reg. 1041/76 & O. Reg. 769/78.

The Child Welfare Act, 1978, S.O. 1978, c.85, as am. S.O. 1979, c.98.

O. Reg. 388/79. O. Reg. 389/79.

The Children's Institutions Act, 1978, S.O. 1978, c.69.

R.R.O. 1970, Regulation 88 as am. O. Reg. 382/72;
O. Reg. 464/79 & O. Reg. 621/79.

The Children's Law Reform Act, 1977, S.O. 1977, c.41.

O. Reg. 176/78.

The Children's Mental Health Services Act, 1978, S.O. 1978, c.67.

O. Reg. 381/79.

The Children's Probation Act, 1978, S.O. 1978, c.41.

The Children's Residential Services Act, 1978, S.O. 1978, c.70.
O. Reg. 382/79.

The Community Psychiatric Hospitals Act, R.S.O. 1970, c.74.
R.R.O. 1970, Regulation 94.

The Compensation for Victims of Crime Act, 1971, S.O. 1971,
Vol.2, c.51.

The Consumer Reporting Act, 1973, S.O. 1973, c.97.
O. Reg. 251/74.

The Coroners Act, 1972, S.O. 1972, c.98, as am.
S.O. 1974, c.103, & S.O. 1978, c.38.
O. Reg. 307/73 as am. O. Reg. 943/78 & O. Reg. 849/79.

The Day Nurseries Act, 1978, S.O. 1978, c.72.
R.R.O. 1970, Regulation 160 as am. O. Reg. 232/71;
O. Reg. 547/71; O. Reg. 239/72; O. Reg. 148/74;
O. Reg. 826/74 & O. Reg. 380/79.

The Denture Therapists Act, 1974, S.O. 1974, c.34.
O. Reg. 42/75.

The Developmental Services Act, 1974, S.O. 1974, c.2.
O. Reg. 213/74 as am. O. Reg. 690/79.

The Drugless Practitioners Act, R.S.O. 1970, c.137.
R.R.O. 1970, Regulation 228. R.R.O. 1970, Regulation 229.
R.R.O. 1970, Regulation 230. R.R.O. 1970, Regulation 231.
R.R.O. 1970, Regulation 232. R.R.O. 1970, Regulation 233.

The Education Act 1974, S.O. 1974, c.109, as am.
S.O. 1976, c.50.
R.R.O. 1970, Regulation 196.
O. Reg. 38/73 as am. O. Reg. 911/78.
O. Reg. 407/78. O. Reg. 555/79.

The Employment Standards Act, 1974, S.O. 1974, c.112.

The Energy Act, 1971, S.O. 1971, Vol.2, c.44.

The Evidence Act, R.S.O. 1970, c.151.

The Family Benefits Act, R.S.O. 1970, c.157, as am.
S.O. 1971, Vol. 2, c.50 & c.92, & S.O. 1974, c.98.
R.R.O. 1970, Regulation 287 as am. O. Reg. 153/71;
O. Reg. 187/73; O. Reg. 715/73; O. Reg. 991/78 &
O. Reg. 993/78.

The Family Law Reform Act, 1978, S.O. 1978, c.2.

The Funeral Services Act, 1976, S.O. 1976, c.83.

The General Welfare Assistance Act, R.S.O. 1970, c.192, as am.

S.O. 1971, Vol.2, c.50.

R.R.O. 1970, Regulation 383 as am. O. Reg. 338/72;

O. Reg. 714/73; O. Reg. 507/76 & O. Reg. 995/78.

The Health Disciplines Act, 1974, S.O. 1974, c.47, as am.

S.O. 1975, c.63.

O. Reg. 576/75. O. Reg. 577/75. O. Reg. 578/75.

O. Reg. 585/75. O. Reg. 579/75 as am. O. Reg. 647/76.

The Health Insurance Act, 1972, S.O. 1972, c.91, as am.

S.O. 1974, c.60 & c.86, & S.O. 1975, c.52.

O. Reg. 323/72.

The Highway Traffic Act, R.S.O. 1970, c.202, as am.

S.O. 1973, c.167; S.O. 1974, c.123, & S.O. 1977, c.54.

O. Reg. 906/76. O. Reg. 44/79.

The Homemakers and Nurses Services Act, R.S.O. 1970, c.203,

as am. S.O. 1973, c.143.

R.R.O. 1970, Regulation 436 as am. O. Reg. 294/76.

The Homes for the Aged and Rest Homes Act, R.S.O. 1970, c.206

as am. S.O. 1972, c.62, & S.O. 1973, c.27.

R.R.O. 1970, Regulation 439 as am. O. Reg. 750/74;

O. Reg. 677/78 & O. Reg. 770/78.

The Homes for Retarded Persons Act, R.S.O. 1970, c.204, as am.

S.O. 1971, Vol.2, c.50, & S.O. 1973, c.76.

R.R.O. 1970, Regulation 437 as am. O. Reg. 439/74.

The Homes for Special Care Act, R.S.O. 1970, c.205.

R.R.O. 1970, Regulation 438 as am. O. Reg. 57/72.

The Human Tissue Gift Act, 1971, S.O. 1971, Vol.2, c.83.

The Income Tax Act, R.S.O. 1970, c.217, as am. S.O. 1971 (2nd Sess.), c.1.

The Insurance Act, R.S.O. 1970, c.224.

The Liquor Licence Act, 1975, S.O. 1975, c.40, as am.

S.O. 1978, c.42.

O. Reg. 1008/75 as am. O. Reg. 781/76 & O. Reg. 533/77.

The Mental Health Act, R.S.O. 1970, c.269, as am.

S.O. 1978, c.50.

R.R.O. 1970, Regulation 576 as am. to O. Reg. 738/79.

The Mental Hospitals Act, R.S.O. 1970, c.270.
R.R.O. 1970, Regulation 578 as am. O. Reg. 843/78.

The Mental Incompetency Act, R.S.O. 1970, c.271.

The Ministry of Community and Social Services Act, R.S.O. 1970,
c.120, as am. S.O. 1974, c.95.

The Ministry of Correctional Services Act, 1978,
S.O. 1978, c.37.
O. Reg. 243/79.

The Ministry of Health Act, 1972, S.O. 1972, c.92.
O. Reg. 39/76.

The Ministry of Treasury and Economics Act, 1978,
S.O. 1978, c.62.

The Nursing Homes Act, 1972, S.O. 1972, c.11.
O. Reg. 196/72 as am. O. Reg. 508/72 & O. Reg. 499/73.

The Occupational Health and Safety Act, 1978, S.O. 1978, c.83.
O. Reg. 658/79. O. Reg. 659/79 O. Reg. 660/79.

The Ombudsman Act, 1975, S.O. 1975, c.42.

The Ontario Guaranteed Annual Income Act, 1974,
S.O. 1974, c.58, as am. S.O. 1977, c.50.

The Ontario Human Rights Code, R.S.O. 1970, c.318, as am.
S.O. 1971, Vol.2, c.50; S.O. 1972, c.119, & S.O. 1974,
c.73.

The Ontario Mental Health Foundation Act, R.S.O. 1970, c.322.

The Police Act, R.S.O. 1970, c.351.
R.R.O. 1970, Regulation 680.

The Private Hospitals Act, R.S.O. 1970, c.361, as am. S.O. 1973,
c.123.
R.R.O. 1970, Regulation 689, as am. O. Reg. 417/71.

The Private Investigators and Security Guards Act,
R.S.O. 1970, c.362.

The Private Sanitaria Act, R.S.O. 1970, c.363.

The Provincial Courts Act, R.S.O. 1970, c.369, as am.
S.O. 1977, c.22.
O. Reg. 386/79.

The Provincial Offences Act, 1979, S.O. 1979, c.4.

The Psychologists Registration Act, R.S.O. 1970, c.372.
R.R.O. 1970, Regulation 698.

The Public Authorities Protection Act, R.S.O. 1970, c.374,
as am. S.O. 1976, c.19.

The Public Health Act, R.S.O. 1970, c.377, as am.
S.O. 1972, c.80; S.O. 1973, c.130; S.O. 1974, c.61 & c.87
& S.O. 1975, c.61.

R.R.O. 1970, Regulation 701.

R.R.O. 1970, Regulation 703 as am. O. Reg. 413/71.

R.R.O. 1970, Regulation 704.

R.R.O. 1970, Regulation 719.

R.R.O. 1970, Regulation 720.

R.R.O. 1970, Regulation 721.

O. Reg. 483/72 as am. O. Reg. 343/73 & O. Reg. 463/73.

O. Reg. 250/74.

O. Reg. 972/75 as am. O. Reg. 926/79.

O. Reg. 39/76.

O. Reg. 426/78 as am. O. Reg. 855/78.

The Public Hospitals Act, R.S.O. 1970, c.378, as am.
S.O. 1972, c.90.

R.R.O. 1970, Regulation 729 as am. O. Reg. 119/71;
O. Reg. 353/71; O. Reg. 170/72; O. Reg. 193/72;
O. Reg. 247/72; O. Reg. 100/74 & O. Reg. 986/78.

The Public Inquiries Act, 1971, S.O. 1971, Vol.2, c.49.

The Public Institutions Inspection Act, 1974, S.O. 1974, c.64.

The Public Service Act, R.S.O. 1970, c.386.

R.R.O. 1970, Regulation 749 as am. O. Reg. 38/71;
O. Reg. 223/72; O. Reg. 1013/75 & O. Reg. 870/77.

The Public Trustee Act, R.S.O. 1970, c.389, as am.
S.O. 1971, Vol.2, c.50.

The Sanatoria for Consumptives Act, R.S.O. 1970, c.422, as am.
S.O. 1972, c.94.

The Statistics Act, R.S.O. 1970, c.443.

The Statutory Powers Procedure Act, 1971, S.O. 1971, Vol.2,
c.47.

The Training Schools Act, R.S.O. 1970, c.467, as am.
S.O. 1978, c.66.
O. Reg. 384/79.

The Trustee Act, R.S.O. 1970, c.470.

The Venereal Diseases Prevention Act, R.S.O. 1970, c.479, as am.
S.O. 1971, Vol.2, c.33.
R.R.O. 1970, Regulation 819 as am. O. Reg. 790/76.

The Vital Statistics Act, R.S.O. 1970, c.483, as am.
S.O. 1973, c.114, & S.O. 1978, c.81.
R.R.O. 1970, Regulation 820 as am. O. Reg. 243/72;
O. Reg. 432/73 & O. Reg. 375/79.

The Vocational Rehabilitation Services Act, R.S.O. 1970, c.484,
as am. S.O. 1971, Vol.2, c.50, & S.O. 1974, c.97.
R.R.O. 1970, Regulation 821 as am. O. Reg. 136/79.

The Workmen's Compensation Act, R.S.O. 1970, c.505, as am.
S.O. 1973, c.173, & S.O. 1975, c.47.
O. Reg. 6/71.

The Physician-Client Relationship

John McGee Porter graduated from medical school in 1944 and was in private practice in the City of Toronto until May 3, 1971. During the period 1965 to May 3, 1971, his practice was confined, for all practical purposes, to the provision to many insurance companies, insurance adjusters and corporations who were self insurers, of medical reports which assessed the scope and nature of injuries suffered by claimants. In May, 1966, Dr. Porter was appointed a coroner and was given a coroner's identification card. His work as a coroner took him to various hospitals in the Judicial District of York, including the North York Branson Hospital. After May, 1971, he ceased to be an active coroner but as late as April, 1978, the time of his involvement in our hearings, Dr. Porter continued to have the status of a coroner and he retained his coroner's identification card.

On May 3, 1971, Dr. Porter became employed by the Province of Ontario as a medical claims adjudicator for the Ontario Health Insurance Plan. He thereupon began to act as a medical advisor in the OHIP Mississauga District Office, adjudicating and clarifying claims which required professional medical knowledge. He was required to maintain a liaison with physicians, clinics, and laboratories in the Mississauga district. His responsibilities and activities included the investigating of unusual claims and practices. From time to time he was required to interpret OHIP policy relating to the claimed right of physicians, in specific cases, to be paid independent consideration, that is, a sum in addition to the usual fee. Dr. Porter's function as an adjudicator quite clearly made him a person the physicians in the Mississauga district would not wish to offend.

The OHIP Mississauga District Office dealt, amongst others, with claims which originated from many hospitals including North York General Hospital, York-Finch General Hospital, Queensway General Hospital and Mississauga General Hospital. On occasion, Dr. Porter attended at hospitals to interview physicians during the course of his employment with OHIP although such visits were not essential to the proper carrying out of his duties. Dr. Porter had his own office, desk, telephone and secretary.

He had access to all microfiche records compiled by OHIP. These records contain the total medical history maintained by OHIP about subscribers and their dependants. Dr. Porter also held an OHIP identification card which bore the insignia of the Province of Ontario and identified him by photograph and name as a medical consultant employed by OHIP.

Scope of Extra-curricular Activities

Dr. Porter admitted that, while employed at OHIP during the period between May 3, 1971, and February 14, 1973, he was retained on various occasions for a fee by insurers and insurance adjusters to carry out medical examinations, review hospital records and give opinions in report form as to the scope of disabilities suffered by claimants who had been involved in motor vehicle accidents. He destroyed his records which would have established the exact number and content of these reports. His estimate was that he had prepared between 20 to 30 reports in this period.

From February 14, 1973, to December 31, 1976, Dr. Porter prepared 46 medical reports for which he was paid. This number was established from his account book. Dr. Porter retained in his possession only 12 of these 46 medical reports. In each of these 12 cases the patient had consented to the release of medical information. Our investigators located 12 additional medical reports. There were, therefore, 22 reports and supporting documents, such as letters of transmittal, which we could not inspect because Dr. Porter had discarded his files and destroyed his copies of the reports and supporting documents. Dr. Porter testified that this destruction of documents was in accordance with his ordinary practice, a practice, it may be added, for which there was no apparent rational explanation. Reports which antedated destroyed reports remained in Dr. Porter's possession. No report containing medical information obtained by him without the patient's authorization remained in his possession. Eight of the twelve reports discovered by our investigators and which were not in Dr. Porter's possession, were reports which contained medical information obtained without the patient's consent. I shall return to these reports later.

I conclude that the destruction of medical reports and supporting documents was not done in accordance with any ordinary practice but was deliberately undertaken by Dr. Porter to frustrate any legitimate inquiry into the nature and scope of his practice of reviewing health records and examining patients without the patients' informed consent. I now turn

to a detailed examination of the eight reports prepared by Dr. Porter without patient consent and the circumstances surrounding them. In accordance with the practice followed throughout our proceedings, the subjects of the reports will not be identified. I should add that the decision to set out the details to be found in the pages that follow was not taken lightly. Verbosity in a report is never desirable and the risk of repetition and resulting reader boredom is high. I have decided, however, that to run the risk is necessary. In no other way can the reader fairly judge the validity of the conclusion I have reached about the quality of Dr. Porter's conduct. No summary can do justice to the facts. Moreover, a recital of the details will afford a basis for comparison with the practices of the private investigators for the insurance industry, a description of which will be given later.

Report on R

R was a pedestrian who had been struck on April 18, 1974, by a motor vehicle insured by Alpena Insurance Company. The adjusting of this loss was assigned by that insurance company to the adjusting firm, Brouwer & Company of General Insurance Adjusters Ltd. Lawrence Lander was then an employee of Brouwer & Company General Insurance Adjusters Ltd. and an experienced adjuster familiar with personal injury cases. He had known Dr. Porter for 12 to 15 years and, during that time, obtained from him 10 to 12 reports of the kind I shall describe shortly.

Mr. Lander was unable to obtain a written authorization from R to obtain medical information and he therefore retained Dr. Porter to determine the extent of R's injuries. When he did so, Mr. Lander knew that R had retained a solicitor and that, in accordance with the recognized custom in the adjusting business, it would not be proper for him or Dr. Porter to deal with or speak directly to R. At the time Dr. Porter received his instructions, Mr. Lander believed that Dr. Porter would either go to the hospital or contact the hospital by telephone to obtain the required health information. Mr. Lander knew that the health information being sought was confidential and that the hospital and its employees had an obligation to ensure its confidentiality. It was implicit in the discussions between Mr. Lander and Dr. Porter, but, in any event, clear to the latter that the former did not have an authorization from R permitting the release of medical information.

Dr. Porter went to The Toronto Western Hospital where R was a patient and carried out a physical examination of him. Before conducting this examination he neither identified himself

as representing an insurer adverse in interest to R nor sought the express consent of R to his examination. He told R that he had been asked to carry out a physical examination by Mr. Lander "for the insurance company". He did not disclose to a nurse or any other person employed by The Toronto Western Hospital that he was acting for a party who was adverse in interest to R. Dr. Porter also reviewed R's chart at the nursing station. He could not recall whether or not he was wearing a hospital or "lab" coat and whether or not a nurse was present at the station at the time he reviewed the chart. Dr. Porter stated that he knew that the chart was the property of the hospital.

Dr. Porter testified that he believed he acted properly in reviewing R's chart without making disclosure of the interest he represented and his intention to review the chart to the nurse on duty. I cannot accept this as a statement of his honest belief. Hospital policy prohibiting anyone not treating a patient from reviewing his or her hospital records was well known to members of the medical profession and no physician, including Dr. Porter, could honestly believe that any other policy was in force. I conclude that, when he reviewed R's charts, Dr. Porter did so surreptitiously, knowing that such review was contrary to hospital policy and improper on his part.

After his visit to the hospital, Dr. Porter prepared a written report, dated April 27, 1974, and had it delivered to Mr. Lander. The report read, in part, as follows:

At your request, I have examined and assessed the above mentioned with reference to the injuries she received on April 18, 1974. At the time of this examination, Mrs. R. was a patient in the Toronto Western Hospital where she has been confined since the above date.

I have been informed that Mrs. R. was a pedestrian when she was struck by a motor vehicle. Following the initial impact, she was crushed between the vehicle and a Hydro pole with the upper part of her right leg bearing the greatest part of the force.

Following this incident, she was taken to the Emergency Department of the Toronto Western Hospital where she was initially examined and assessed by the doctor on duty. Because of seriousness and extent of her

injuries she was transferred to the medical care of Dr. W, an orthopaedic surgeon on the staff of the hospital.

The main and, I believe, the only injuries sustained by Mrs. R. have been confined to the upper part of the right leg. Here she sustained a compound, comminuted fracture of the shaft of the right femur. She was also extensive soft tissue injury to this area.

Because of the type of fracture, an open reduction was mandatory. Mrs. R. was taken to the operation room where the fracture was reduced and immobilized by the placement of an intramedullary rod, namely a #15 nail. This nail was placed through the greater trochanter of the femur and transfixated the fracture fragments. The anterior compartment of the upper leg was also opened to relieve pressure therein. At this time it was noted that there had occurred a rupture of the Tibialis Anterior muscle. This muscle was satisfactorily repaired and sutured. Following the surgical procedure, it was noted that the pulse of the right Dorsalis Pedis artery was absent. There was no accompanying evidence of ischemia or absent blood supply to the lower leg.

On the day following the surgery, the pulse of the Dorsalis Pedis artery had returned and with its return, all concern regarding the viability of the extremity vanished.

The right lower leg was encased in a pressure dressing and placed on a Thomas splint. It retains that position at the present time.

Because of the local superficial trauma to the skin of the left leg, further surgical debridement was necessary. The skin in the area of the compound fracture lost its viability and died. This skin and subcutaneous tissue was surgically removed on April 23, 1974.

It is not certain at this juncture whether further surgical debridement will be necessary. A skin graft may also be necessary to close the skin defect.

I believe that the prognosis is good in this case. There is no reason to believe that the healing of the fracture will not continue undisturbed and full function will return to the leg. The intramedullary rod may or may not be removed at some later date. There will probably be a gross soft tissue defect in the area but this will be cosmetic and not functional in its effect.

At the time of my examination, Mrs. R. was laying quite comfortably in bed and not in pain. She was fairly well immobilized by the Thomas splint but could move about freely within its confines. Movement of the leg will be quite permissible shortly but weight bearing will not be possible for some months.

I would predict that all will go well and no complications should develop. If they do they can be estimated at the time. I do not believe a further examination and assessment should be required for many months - full function and use should have returned before a permanent estimate of disability could be attempted. If any examination of this nature at that time is indicated, please let me know.

Hoping that this report will be of assistance in your assessment of this, I remain;

By letter dated May 27, 1974, Mr. Lander reported to Alpena Insurance Company and enclosed Dr. Porter's report. The report to the Alpena Insurance Company contained the following statement:

"I made immediate contact with the claimant's husband who advised me that he had retained a lawyer. With a lawyer involved it was impossible for us to obtain written authorization to secure medical evidence, however, the writer was successful

in securing confidential medical information from Dr. John Porter, who normally assists me in matters of this nature. We attach a report dated April 27, 1974, from Dr. Porter and you will find this self-explanatory. I should emphasize that this confidential report is, for obvious reasons, for our use in assessment purposes only and under no circumstances is the contents of the report to be used or Dr. Porter's name to be divulged or in any way identified with the information received."

I conclude that Mr. Lander stressed the confidential nature of the report and pointed out that the report was not, under any circumstances, to be used or Dr. Porter's name disclosed because he knew that Dr. Porter's behaviour had been improper.

Mr. Pinkerton's Historical Involvement with Dr. Porter

John C.G. Pinkerton was an experienced and knowledgeable adjuster. He had known Dr. Porter before 1971 and had made use of his services to examine claimants, with their consent, in their homes. Dr. Porter was the only physician Mr. Pinkerton knew who had a black bag and would travel to a claimant's home to examine the claimant. In 1971, Mr. Pinkerton became aware that Dr. Porter left private practice to join OHIP. In the period, May, 1971, to September, 1974, while Dr. Porter was employed by OHIP, Mr. Pinkerton consulted Dr. Porter and, on occasion, had him explain the significance of medical terms, and comment upon opinions and prognoses expressed by other physicians in medical reports which he had received. Dr. Porter, from time to time, paid a fee for his services but on some occasions he received no compensation. In the same period, May, 1971, to September, 1974, Mr. Pinkerton retained Dr. Porter three times to speak to claimants' treating physicians for the purpose of obtaining medical information from them without their patients' knowledge or consent with respect to the injuries suffered by each claimant and the prognosis. Dr. Porter was successful in obtaining this medical information on two of the three occasions.

By his own admission, before September, 1974, Mr. Pinkerton believed that it was illegal, unethical, and actually impossible for anyone, including a physician other than the treating physician, to review a patient's hospital record without the consent of that patient.

Report on K

K was the operator of a motor vehicle which, in November of 1974, was struck by a motor vehicle insured by Economical Mutual Insurance Company. Mr. L. Palin was the claims person at that insurance company who assigned the adjusting of this claim to Mr. Pinkerton. On the receipt of the assignment, Mr. Pinkerton immediately spoke to K's husband who had difficulty speaking English. Mr. Pinkerton was unable to obtain K's authorization to permit the release of medical information, but learned from her husband that K had been admitted to Queensway General Hospital.

In his evidence, Mr. Pinkerton said that it was his belief that, acting in accordance with his usual practice, he had received Mr. Palin's authority on behalf of the company to retain Dr. Porter to obtain particulars of K's injuries. Messrs. Palin and Pinkerton both knew at all times that K had not authorized anyone on behalf of Economical Mutual Insurance Company to review any of her medical records.

On or about November 26, 1974, Mr. Pinkerton telephoned Dr. Porter and asked him to determine the nature and extent of K's injuries. Dr. Porter's evidence was that he believed that Pinkerton had an ethical obligation, if he was not in possession of K's written authority to release health records, to inform him of that fact, and that in the absence of such information, he would be justified in assuming, as he did assume, that Mr. Pinkerton had her authorization. Dr. Porter knew that if Mr. Pinkerton had K's written authorization, he, Mr. Pinkerton, could write directly to the Queensway General Hospital and, for a small fee, obtain copies of the hospital records. Dr. Porter, on the other hand, could obtain access only to parts of these records. It is reasonable to assume, and anyone as experienced in the personal injury field as Dr. Porter was, must have assumed, that Mr. Pinkerton would not have called upon Dr. Porter if he had had such an authorization. I conclude that Dr. Porter knew that he was being retained precisely because Mr. Pinkerton could not obtain K's authorization to release medical records. It was implicit in the discussion between Mr. Pinkerton and Dr. Porter that the former did not have an authorization signed by K in his possession. Mr. Pinkerton certainly did not mislead Dr. Porter. I simply cannot accept Dr. Porter's statement that he believed that Mr. Pinkerton had obtained K's authorization to the release of her medical records.

In the carrying out of his assignment from Mr. Pinkerton, Dr. Porter telephoned the Queensway General Hospital and spoke

to an unknown person in the x-ray department. He identified himself as Dr. Porter and requested the results of K's x-rays. He was not asked whether he had the patient's consent or whether he was her treating physician. He did not disclose that he did not have K's consent or that he was retained by an adjuster representing a party adverse in interest to K. Dr. Porter testified that he believed that he had no obligation to make such a disclosure. I find it incredible that Dr. Porter would impose upon Mr. Pinkerton, the adjuster, the obligation expressly to disclose the absence of a patient's written authorization but would disclaim a similar obligation on his own part to disclose to hospital personnel the absence of authorization on his part. That he sought information from the x-ray department is in itself significant. He could have obtained the information that the x-ray department had and substantially more from the medical records department, but was more likely to be met by a demand for production of K's authorization from that quarter. Dr. Porter's decision to approach the x-ray department shows that he knew that Mr. Pinkerton did not have K's authorization. Dr. Porter acknowledged that his failure to make such a disclosure left him "open to criticism". This is an understatement. Dr. Porter's failure to make disclosure of the interest he represented and his approach to the x-ray department satisfies me of his intention to act deceptively.

On November 29, 1974, Mr. Pinkerton reported to Economical Mutual Insurance Company, to Mr. Palin's attention, as follows:

Relative to your request of November 28, I am attaching statements of the insured and the insured's passenger along with a plan of the accident and the accident report.

I have not yet received the police report.

Dr. Porter spoke to the Queensway X-ray Department and as of November 28 the only x-rays on record for Mrs. K are for the chest. There were no x-rays of the legs or knees and there has been no subsequent x-rays made of the chest.

This suggests to Dr. Porter that there could have been no substantial injury of the leg and no serious problem with the lungs. He says that if there had been any question of a damaged lung or a pulmonary embolism, further x-rays would have been done.

Unfortunately, Dr. Porter's contacts at the Queensway Hospital extend no further than the x-ray department. He is not too keen to make further inquiries by personal attendance unless you feel that it is really essential. [emphasis added]

I am trying to get the claimant's husband to agree to my securing a medical report. It is my suggestion that for the time being, the original recommended reserve be maintained for this injury.

During his evidence, Mr. Pinkerton explained that he intended the sentences, "Unfortunately, Dr. Porter's contacts at the Queensway Hospital extend no further than the x-ray department. He is not too keen to make further inquiries by personal attendance unless you feel that it is really essential", to mean that he believed Dr. Porter was prepared to attempt to obtain further information from the treating physician only. However, at the time he wrote this letter, Mr. Pinkerton was in possession of Dr. Porter's report dated November 28, 1974, which read, in part, as follows:

I have not visited Mrs. K personally in the hospital nor have I sought further information from hospital records. If this is desirable, please let me know.

It appears clear that Dr. Porter was prepared to seek information from "hospital records". The evidence leads to the conclusion that when Mr. Pinkerton reported to the Economical Mutual Insurance Company, he knew that Dr. Porter was prepared to seek information from hospital records and his report of November 28, 1974, was intended by him so to advise the company.

Reports on Mr. and Mrs. Z

Mr. and Mrs. Z were the occupants of a motor vehicle involved in a collision with a motor vehicle insured by the Economical Mutual Insurance Company. William Pope was an employee of that insurance company and assigned the adjusting of a portion of this claim to Mr. Pinkerton. The accident took place in northern Ontario in October, 1974. Eventually Mr. and Mrs. Z were moved to the Toronto General Hospital because of the severity of their injuries. Mr. Pinkerton was instructed to obtain particulars of the injuries and visited Mr. and Mrs. Z in

the Toronto General Hospital. He formed the conclusion that Mr. Z was not in a condition to sign an authorization to permit the release of medical information since, as he candidly stated, Mr. Z could barely talk. Mr. Pinkerton spoke to Mrs. Z who advised him that she and her husband had retained a lawyer. In accordance with the custom in the adjusting business, Mr. Pinkerton then immediately withdrew, reported what he had learned to Mr. Pope at the Economical Mutual Insurance Company, and was instructed to close his file.

On October 23, 1974, Mr. Pinkerton was telephoned by Mr. Pope, was asked to re-open his file and to take over the adjusting and investigation of the claim relating to Mr. and Mrs. Z. At the time of this telephone conversation, Messrs. Pope and Pinkerton both knew that a lawyer was acting for Mr. and Mrs. Z and that no authorization had been signed by either Mr. or Mrs. Z which would permit the release of medical information to third parties. During this conversation a decision was made to retain Dr. Porter. A note in Mr. Pinkerton's file says "put Dr. Porter on". In the report to the Economical Mutual Insurance Company, dated November 15, 1974, directed to Mr. Pope, Mr. Pinkerton wrote:

As instructed, I have assigned Dr. Porter to develop some medical background on the claimants at Toronto General Hospital and as soon as I have this information it will be passed along to you.

As a result of the instructions which he received from Mr. Pope, Mr. Pinkerton telephoned Dr. Porter at his OHIP office. He eventually spoke to Dr. Porter and told him that Mr. and Mrs. Z were patients at the Toronto General Hospital and asked Dr. Porter to find out whether or not Mr. Z was a paraplegic and, for good measure, to determine the extent of Mrs. Z's injuries.

Mr. Pinkerton neither expressly nor implicitly led Dr. Porter to believe that he was in possession of authorizations signed by Mr. and Mrs. Z which would permit the release of their medical information. On the contrary, it was implicit in his discussion with Dr. Porter that no such authorizations were available and that this was the reason Dr. Porter was retained. Mr. Pinkerton said that he believed that Dr. Porter would speak to the attending physician. However, he did not discuss with Dr. Porter the manner in which the information was to be obtained or, in the word used in the trade, "developed".

Dr. Porter thereupon attended at the Toronto General Hospital on November 17, 1974. He reviewed the medical records of Mr. and Mrs. Z at the nursing station and made notes from the records. He did not identify himself to anyone in authority. Dr. Porter could not remember whether or not, on this occasion, he had donned a lab coat. When he reviewed these records Dr. Porter, by his own admission knew that Mr. and Mrs. Z had not consented to his review and that his so doing was improper and unethical. The following exchange appears in the transcript of the hearing:

Q. Did you go over and take out from the bank of charts that chart, the records that relate to Mr. Z?

A. Yes.

Q. Did you make notes from the chart?

A. Yes.

Q. Does your report, the first, page one, page two and the first part of page three, did all that information come from those hospital records?

A. I would imagine so, Mister Strosberg. I, would imagine so. Yes.

Q. When you did that....

A. Without reading it.

Q. When you did that, as I understand it, you did it knowing that you did not have the patient's consent to do it?

A. Yes.

Q. I take it that you would admit that that was improper of you?

A. Yes.

Q. Unethical?

A. At this point in time, yes.

Q. Well when you did it then, was there any doubt in your mind that it was unethical for you to have done it?

A. Yes. I mean, no. There is no doubt... I'm sorry.

Q. Had you dealt, I'll put it to make sure there is no misunderstanding. Did you believe at the time that you were looking at these charts that it was unethical for you to be looking at them?

A. I don't think it really crossed my mind. If I was asked at the time, the answer would be yes.

Dr. Porter's report on Mr. Z read, in part, as follows:

At your request I have attempted to determine the injuries sustained by the above-mentioned 25 year old young man following an automobile accident on September 14, 1974.

I understand that Mr. Z was the driver of a quickly moving vehicle (an automobile - a Gremlin) which was involved in a head-on collision with another quickly moving motor vehicle (an automobile). I understand that, following the collision, Mr. Z was ejected from the vehicle. This fact would indicate that, at the time of the collision, Mr. Z was not wearing any safety belt. However, from reports available to me, I understand that the vehicle was completely demolished so no comment can be made referable to the lack of use of this equipment.

Following this incident, Mr. Z was taken to the Emergency Department of the Lindsay Hospital. Here he was presumably examined and assessed by the doctor on duty and, because of the seriousness and extent of his injuries, he was immediately transferred to the Toronto General Hospital where he was admitted under the professional care of Doctor L.

On admission to the hospital in Lindsay, Ontario it was noted that Mr. Z was completely paralyzed from the lower chest region downwards. He also had sustained fractures of many bones of his body and also had sustained internal traumatic injuries. It was because of the extent of his injuries that he was transferred to the Toronto General Hospital.

Mr. Z's main injury as to the degree of seriousness and certainly from the standpoint of his future, was probably a fracture of the eighth thoracic vertebrae. This fracture presumably completely transected his spinal cord at this level so that a complete paralysis or paraplegia was occasioned from this level downwards. This type of paraplegia would involve both lower legs, bowel and bladder and many skin sensations. There has been no specific treatment directed to this fracture nor will any remedial procedures be possible to alleviate the paraplegia. It is now over one month since this accident so that I would imagine this paraplegia is of a permanent nature.

Mr. Z also sustained fractures of many bones of his body. There was a fracture of the sternum which has necessitated no further treatment. There was a fracture of the nose which was associated with multiple lacerations of the face. These lacerations were surgically repaired immediately following this accident and the fracture of the nose was reduced. There was a fracture-dislocation of the Odontoid process of the cervical vertebrae. There was a fracture of the right and also of the left ankle. The right medial malleolus and the left lateral malleolus were fractured. There was a compound fracture of the left tibia and fibula and this fracture has since been repaired by an open reduction utilizing bone screws and a plate.

Because of the possibility of a traumatic intra-abdominal lesion, a laparotomy was

performed on September 15, 1974. This investigation revealed the presence of a hematoma of the liver, a scratch on the spleen, and bleeding into the mesocolon. These injuries would be considered relatively minor, required no surgical treatment and will heal spontaneously.

Because of breathing difficulty, a tracheostomy has been performed. I understand that this procedure has been terminated sometime prior to the date of my investigation.

There was some concern whether a traumatic aneurysm had been caused by these internal injuries. A thoracic angiogram was performed and this procedure was reported as being within normal limits. This would indicate that, at least at the time of its performance, there was no such lesion.

Immediately following his admission, Mr. Z demonstrated gross hematuria. However, interventional pyelography did not demonstrate any surgical lesion of the kidney or the various urinary apparatus.

X-rays revealed multiple fractures of the pelvis which created gross pelvic instability. There was also a separation of the symphysis pubis.

Fractures of the right ribs, associated with an abrasion over the mid sternum and a fracture of the sternum itself created breathing difficulty but I understand that these have since been remedied.

From a review of the medical record, it has been rather difficult to piece together the chronological treatment which has been necessary for Mr. Z. I was unable to interview Mr. Z himself nor was I able to view his body on some other pretext. However, there was not noted any serious concern with regard to Mr. Z's life but his future certainly is rather dim. [emphasis added]

Mr. Z has been examined and assessed by many specialists including Doctor J of the Rehabilitation Foundation.

There was also some note that Mr. Z's transfer to Buffalo could be possible if suitable arrangements for transit and acceptance in Buffalo were made. I am unable to comment on this aspect of his treatment due to lack of the necessary information.

His report on Mrs. Z read as follows:

Dear Mr. Pinkerton:

Re: Mrs. Z

At your request I have attempted to determine the injuries suffered by the above-mentioned, 21 year old young lady following an automobile accident on September 14, 1974.

I understand that Mrs. Z was the passenger, presumably sitting in the right front seat, of a moving motor vehicle (a Gremlin) which was involved in a head-on collision with another moving vehicle (an automobile?)

Following the collision, I have no knowledge as to the course Mrs. Z's body took through the air nor with what her body came in contact. I also do not know whether she was ejected from the vehicle.

Following this occurrence, Mrs. Z was taken by ambulance to the Emergency Department of the Lindsay Hospital. Possibly because of her injuries or because of the injuries sustained by her husband, the driver of the involved vehicle, she was transferred to the Toronto General Hospital. Here she was admitted on the day of the accident.

According to the hospital records, Mrs. Z sustained a fracture of the lower third of the right femur. She also sustained multiple lacerations of her face and

presumably a renal or urinary bladder contusion.

The fracture of the right femur was treated by the insertion of a Steinman pin through the right tibia in order to provide skeletal traction. To the best of my knowledge this traction would still be in place as of this date.

There was evidently macroscopic hematuria which would be indicative of some traumatic contusion of the urinary apparatus. No specific investigation nor treatment was necessary for this condition, watchful expectation was followed. I do not believe that any further complications have developed in this department.

I unfortunately have been unable to determine the extent or degree of seriousness of the facial lacerations. Suffice it to note that these lacerations were surgically repaired and hopefully their long ranging cosmetic defect will not be serious.

The continuing treatment will be to leave Mrs. Z's right femur in traction for a period of six-eight weeks. Following this period of time, the skeleton traction will probably be able to be removed but no weight bearing will be allowed for possibly three months. Following this time ambulation can be started with the expectation of a full recovery.

It should be noted that I did not discuss this incident with Mrs. Z nor was I able to view her on any pretext. For this reason I cannot make any comment with regard to the seriousness nor the sequelae of the facial lacerations. However, there is no reason to believe that the fracture of the right femur will be of any long lasting consequence. Full recovery should ensure with no difficulty in gait or leg length. [emphasis added]

At the time of my examination Mrs. Z was a patient in a semi-private room, along with her husband, in the Toronto General Hospital. I understand that her return to Buffalo may be imminent depending upon the medical condition of her husband. For this reason if any specific examination is necessary or can be authorized, it should be done in the near future.

Hoping that this report will be of assistance in your handling and assessment of this claim, I remain,

In both reports Dr. Porter used the word "pretext". His report relating to Mr. Z said: "I was unable to interview Mr. Z himself nor was I able to view his body on some other pretext." His report relating to Mrs. Z said: "It should be noted that I did not discuss this incident with Mrs. Z nor was I able to view her on any pretext." Asked to explain the meaning of these sentences, Dr. Porter said that he meant that he was "unable to interview Mr. Z or had no...authority to interview Mr. Z". He denied that he intended "pretext" to mean "ruse or trick".

In all of his reports Dr. Porter exhibited precision in his use of the English language. In a report relating to P, to be dealt with later, he wrote:

It should be noted that I did not at any time discuss these injuries with Miss P nor did I have the advantage of examining her personally.

In his report relating to K he said:

I have not visited Mrs. K nor have I sought further information from the hospital records.

"Pretexts" were the subject of a substantial portion of the evidence given during our investigative hearings. The word "pretext", in its ordinary meaning, is defined in Webster's New Collegiate Dictionary as "a purpose or motive alleged or an appearance assumed in order to cloak the real intention or state of affairs." From the evidence given, I know that this definition is reasonably close to the meaning the word bears in the insurance industry. In this context, a pretext is a misrepresentation, deception, ruse, or trick resorted to cause a person to carry out or submit to an act, or impart information. The

word is and was well known in the insurance industry to have this meaning. It was, and is, a term of art. Because he was so intimately, and so long involved with insurance matters, Dr. Porter must have known what the word "pretext" meant in the context of liability insurance affairs. I have no doubt that Dr. Porter attempted to view Mr. Z's body and Mrs. Z's body by use of a misrepresentation, deception, ruse or trick but, for some unknown reason or reasons, was unsuccessful.

When Mr. Pinkerton received the reports relating to Mr. and Mrs. Z he was, according to his evidence, "angry, and very upset". Mr. Pinkerton said that he believed that Dr. Porter's actions were "improper and illegal" and that if knowledge of those actions became public, there would be trouble for Dr. Porter and himself. He added that Mr. Pope was also angry, upset, and annoyed upon learning of Dr. Porter's activities. Nevertheless, neither of these gentlemen communicated their criticism or displeasure to Dr. Porter in any way. Mr. Pinkerton believed that Dr. Porter intended to charge between \$25.00 and \$50.00 for the services Mr. Pinkerton contemplated. The total fee actually charged was \$130.00 and this larger amount was paid without complaint or comment.

Mr. Pinkerton professed outrage on receipt of Dr. Porter's reports but his outrage was, in reality, based upon a distinction without a difference. The following exchange at the hearing is instructive:

MR. COMMISSIONER: Your current understanding is that if Doctor A, who is the attending physician, gives information about his patient to Doctor B, who is not acting for the patient, that is proper. Or that is not improper?

A. It is my understanding that that is allowable.

MR. COMMISSIONER: Provided Doctor B does not pass that information outside the medical profession?

A. Out...that's right.

MR. COMMISSIONER: Otherwise it is your understanding that doctors can, among themselves, give all the information they want about their patients to each other?

A. Yes.

MR. COMMISSIONER: That's your current understanding?

A. That's my understanding. And it's not.. well.

MR. STROSBERG: Q. I take it that that was what your belief was, your understanding was in November of 1974.

A. Yes.

It seems, then, that Mr. Pinkerton believed that it was improper for Dr. Porter to impart to him medical information about a patient which Dr. Porter had received from the treating physician. However, despite that belief, Mr. Pinkerton agreed that Dr. Porter be instructed to obtain particulars of Mr. and Mrs. Z's injuries and to provide that information to him and, through him, to Economical Mutual Insurance Company. They therefore knowingly became involved in an improper activity even as defined by Mr. Pinkerton. To the extent that Mr. Pickerton's professed feeling of outrage at what he considered to be Dr. Porter's over-exuberance in reviewing the Toronto General Hospital records relating to Mr. and Mrs. Z was genuine, it was based upon his realization that Dr. Porter had acted foolishly and that he, Mr. Pope and their company would suffer embarrassment if Dr. Porter's activities became known to the lawyer acting for Mr. and Mrs. Z. It was not the result of moral indignation at Dr. Porter's actions but simply a realistic understanding of what was necessary to survive in the insurance field without unnecessary criticism or embarrassment. These employees of Economical Mutual Insurance Company believed that they required particulars of the scope of Mr. Z's injuries. They were unconcerned when they retained Dr. Porter with the manner in which this information might be obtained by him. They gave no instructions to Dr. Porter but their unstated wish was that only reasonable risks be taken. However, their idea of a reasonable risk did not coincide with that of Dr. Porter. I believe that Mr. Pinkerton and Economical Mutual Insurance Company knew that Dr. Porter was to act improperly when he was retained. Put another way, despite their dissatisfaction, in retrospect, with Dr. Porter's reports, Mr. Pinkerton and Economical Mutual Insurance Company must have known that an unauthorized review of the Toronto General Hospital's medical records by Dr. Porter was likely to result from his retainer.

Report on C

C, an 86-year-old woman, was a pedestrian who had been struck on December 18, 1975, by a motor vehicle insured by Zurich Insurance Company. The adjusting of this claim was assigned by that insurer to Lander-Spiers Insurance Adjusters Ltd., an Ontario company whose principal shareholders were Lawrence Lander and Michael Spiers. On receipt of the assignment and with his client's full knowledge, Mr. Lander telephoned Dr. Porter on December 19, 1975, at his OHIP office. He informed Dr. Porter that C was a patient at the York-Finch General Hospital and asked Dr. Porter to ascertain the extent of C's injuries. During this telephone conversation there was no reference to the question whether or not Mr. Lander possessed an authorization signed by C to permit the release or disclosure of her health information. Dr. Porter testified that he believed that Mr. Lander had C's authorization to permit him, Mr. Lander, to review the York-Finch General Hospital's records relating to C. If Mr. Lander had had such an authorization in his possession, it would not have been necessary to retain Dr. Porter. For a small fee, with an authorization, Mr. Lander could have secured a copy of C's complete York-Finch General Hospital records. Dr. Porter knew this and he also knew that, by securing a copy of C's complete York-Finch General Hospital records, Mr. Lander could obtain more information at a smaller cost than that involved in retaining Dr. Porter. It was implicit in his discussion with Dr. Porter that Mr. Lander was not in possession of an authorization executed by C to permit a review of her medical records. I cannot accept Dr. Porter's statement that when he went to York-Finch General Hospital he believed that Mr. Lander was in possession of an authorization from C. Had he honestly believed that Mr. Lander had such an authorization, he would have asked for a copy to facilitate his access to the complete hospital records at the nursing station and in the medical records department.

On attending at York-Finch General Hospital, Dr. Porter discovered that C was asleep. He had intended to examine C physically but did not do so because, he said, he did not want to disturb her. Dr. Porter did not identify himself to the supervising nurse, did not disclose that he was acting on behalf of an insurer who was adverse in interest to C, and did not request permission from a person in authority to inspect C's chart. Dr. Porter reviewed C's chart at the nursing station and later made a written report to Mr. Lander, dated December 21, 1975, which stated, in part, as follows:

Following this collision, Mrs. C was taken by ambulance to the Emergency Department of

the York-Finch General Hospital. Here she was initially examined and assessed by the Doctor on Duty but has since been under the professional care of Dr. L, an Orthopedic Surgeon.

On admission to the Emergency Department, it was noted that Mrs. C had sustained injuries to her right leg. To the best of my knowledge this was the only and main injury sustained by this claimant. It should be noted that I did not discuss the incident with Mrs. C nor did I examine her to any degree.

X-rays were taken of the right leg and these x-rays, which I have personally examined, revealed the presence of an intertrochanteric fracture of the right femur. This fracture was treated by Open Reduction and immobilization by the placement of a pin and plate. Postoperative x-rays revealed this procedure to have been carried out quite satisfactorily in that the fracture was in good alignment and stability.

With a letter dated January 23, 1976, Mr. Lander forwarded Dr. Porter's report to Zurich Insurance Company and requested a cheque payable to Dr. Porter in the sum of \$75.00. The cheque was issued in due course and delivered to Dr. Porter. Mr. Lander's report to the insurance company dated January 23, 1976, contained the following statement:

In view of the importance of securing some medical information relative to the third party's injuries we arranged for our medical consultant, John Porter, M.D. to make discreet enquiries. Attached is Dr. Porter's confidential report of December 21, 1975, outlining his findings, and you will find this self-explanatory. [emphasis added]

In retaining Dr. Porter to acquire health information about C, Mr. Lander expected that Dr. Porter would go to the hospital to obtain that information. Mr. Lander knew that it was improper for a physician, other than the patient's physician, to obtain information of that kind. It was for that reason that Mr. Lander suggested that Dr. Porter's report be treated confidentially. He knew, with reasonable probability, if not

certainty, that in obtaining health information from the hospital records without C's authorization, Dr. Porter would be acting improperly.

After receiving the report relating to C, Zurich Insurance Company neither chastised nor criticized Mr. Lander for obtaining a report of that kind. I am persuaded that Zurich Insurance Company knew that Dr. Porter was to be retained by Mr. Lander on its behalf to acquire health information without the patient's authorization.

Report on M

M was a pedestrian who had been struck on December 23, 1975, by a motor vehicle insured by Provincial Services Agency of which Praim Singh was the claims manager. The adjusting of this claim was assigned by Provincial Services Agency to Lander-Spiers Insurance Adjusters Ltd. On receipt of the assignment, Mr. Lander spoke to M's wife and learned from her that M was in a hospital and that a solicitor had been retained. He then called North York Branson Hospital and confirmed that M was a patient there. Mr. Lander spoke to Mr. Singh and advised him that he believed that Dr. Porter would obtain medical information without the patient's authority and was authorized by Mr. Singh, on behalf of Provincial Services Agency, to retain Dr. Porter to obtain medical information about M without his consent. Mr. Lander telephoned Dr. Porter at the Mississauga District office of OHIP. He frankly admitted that if he had been in possession of M's written authorization to obtain hospital records or reports from attending physicians he would not have needed Dr. Porter's services. He would, himself, have gone or written to North York Branson Hospital and would have received all relevant medical information for a smaller fee than that he expected he would have to pay to Dr. Porter.

At some time after May 3, 1971, and certainly before December, 1975, Mr. Lander knew that Dr. Porter was an employee of OHIP but continued to retain him to provide the services to be described despite this knowledge. Mr. Lander spoke to Dr. Porter, advised him that M was a patient in North York Branson Hospital and requested him to obtain whatever information he could get about M's condition. There was no express reference to the question whether Mr. Lander possessed M's written authority to permit the release or review of his medical records. Mr. Lander did not in any way mislead Dr. Porter into believing that he had M's authorization. Dr. Porter's evidence was that he spoke to Mr. Lander in December and, at that time, believed that Mr. Lander was in possession of an authorization

from M which would permit him to review M's medical records. I do not accept Dr. Porter's evidence and am convinced that at all times he actually knew that Mr. Lander did not have M's authorization to permit the review of medical records. A physician as experienced in personal injury matters as Dr. Porter could not have failed to know that, with M's authorization, Mr. Lander could obtain from North York Branson Hospital a copy of M's hospital records and that his services would therefore not be needed.

Dr. Porter went to the North York Branson Hospital intending to physically examine and question M. Dr. Porter was familiar with the hospital because he had been there in his capacity as a coroner on 20 to 30 occasions. He knew the x-ray department and the manner in which the index to the x-rays and the x-ray films themselves were kept. In the x-ray department he was known as Dr. Porter, the Coroner. On at least two occasions, prior to December 23, 1975, Dr. Porter had been seen by the personnel in the x-ray department using the x-ray index and personally obtaining x-rays. He was not challenged by the x-ray staff on these two occasions because the employees believed that he was on Coroner's business. Dr. Porter did, in fact, examine M's x-rays but he did not carry out a physical examination of him. He did not identify himself. He did not declare that he was acting for an insurer who was adverse in interest to M either in the x-ray department or at the nursing station.

A report relating to M, dated January 4, 1976, was sent by Dr. Porter to Mr. Lander. The report read, in part, as follows:

At your request I have determined the injuries sustained by the above-mentioned... gentleman following a motor vehicle-pedestrian collision on December 23, 1975 at approximately 11:20 hours. I understand that M was crossing a roadway when he was involved in the above incident.

Following this occurrence, M was taken to the Emergency Department of the North York Branson Hospital. Here it was noted that M's injuries were mainly confined to the right lower leg. X-rays revealed the presence of a compound, comminuted fracture of the proximal third of the right tibia. There was a large, triangular fragment which was displaced only slightly laterally and

forward. There was also an associated fracture of the neck of the right fibula. Because of these injuries it was necessary to admit M to hospital. At the time of this investigation, M remains a patient in the hospital.

Following admission, there was evidently some concern with regard to the cardiovascular status of this injured man. For this reason he was examined and assessed by Dr. T a specialist in Internal Medicine. Dr. T noted that there was initially some evidence of hypertension but the blood pressure readings which were initially in the order of 190/100 soon returned to a normal level of 120/80. There was no further evidence of any serious cardiovascular disease that was not consistent with the age of this person.

Following M's admission to hospital, he complained of much pain in many areas of the body, particularly the shoulder area. Multiple x-rays of the vertebral column revealed the presence of narrowing of the intervertebral disc spaces between C4 and C7. There was also evidence of advanced osteoporosis at all levels. There was a suggestion of a non-displaced fracture of the superior ramus and of the interior ramus of the right bone. Further x-rays were indicated but I do not know whether these x-rays have, at this date, been taken. In any event, fractures of this area would be inconsequential except for the presence of some pain. Healing will always take place and no permanent disability can ensue.

The solicitor acting on behalf of M discovered at an examination for discovery that Dr. Porter had carried out an unauthorized review of M's North York Branson Hospital records. By letter dated the 7th day of October, 1976, M's solicitor made a formal complaint of professional misconduct on the part of Dr. Porter to The College of Physicians and Surgeons of Ontario. Under the College's procedure all complaints, at first instance, are referred to its Complaints Committee. The Complaints Committee then decides whether a complaint ought to be referred to the Discipline Committee for a full hearing. Counsel

retained by Dr. Porter made representations in writing to the Complaints Committee by letter dated October 25, 1976. In part, this letter read as follows:

I do, however, want to tell you that as far as Dr. Porter is concerned he would not have examined the records if he had known that the appropriate consents had not been obtained at that time.

The Complaints Committee heard no oral evidence and decided that no inquiry ought to be held by the Discipline Committee because, in its opinion, the material presented did not warrant a charge of professional misconduct. This decision was based upon an assumption that Dr. Porter's counsel's representation was accurate.

Pursuant to the provisions of The Health Disciplines Act, 1974, S.O. 1974, chapter 47, M's solicitor asked the Health Disciplines Board to review the Complaints Committee's decision. On June 3, 1977, the Health Disciplines Board reviewed the complaint and heard evidence from Dr. Porter, who told the Board that if he had known that M had not consented to his review of his hospital records he would not have carried out the review. He also told the Board that the M matter was the only occasion on which he had carried out an examination of hospital records without authorization. Dr. Porter made this statement intending the Health Disciplines Board to believe it was true. In its decision of July 6, 1977, the Health Disciplines Board confirmed the decision of the Complaints Committee. The decision and reasons of the Board are, in part, as follows:

In the proceedings before the Health Disciplines Board, Dr. Porter readily admitted that he had no right to obtain Mr. M's records from Branson Hospital but that he had not acted in bad faith, having over the years prepared hundreds of similar reports, many of them for this particular adjuster, and had assumed that the latter had obtained the necessary consent. Dr. Porter's counsel argued that while Dr. Porter may have committed a technical breach of the regulation, it should not be construed as misconduct, especially as Dr. Porter's report had not been prejudicial to Mr. M who was not, incidentally, the doctor's own patient, and that the parties for whom Dr. Porter acted could have

obtained a subpoena giving access to the hospital records.

The Board attaches great importance to the protection of a patient against unauthorized disclosure of medical information. Nonetheless, it agrees with The College of Physicians and Surgeons of Ontario that a strict and literal interpretation of the regulation would create serious difficulties precluding, for example, a doctor from giving a husband information about his wife's condition without specific authorization in advance. The Board feels that in this particular case there were extenuating circumstances, and agrees with the Complaints Committee's conclusion that Dr. Porter should not be prosecuted for professional misconduct.

The Board, accordingly, confirms the decision of the Complaints Committee of The College of Physicians and Surgeons of Ontario.

On November 30, 1977, the *Globe and Mail* carried the following report of the Health Disciplines Board decision:

Insurance adjuster benefited

M.D. scolded for giving out hospital data

An Ontario doctor has been cautioned by the College of Physicians and Surgeons for obtaining medical hospital records of patients, not his own, for an insurance adjuster without the patients' permission or a court order.

The Health Disciplines Board released the findings of the college yesterday, shortly after Health Minister Dennis Timbrell had told the Legislature it was impossible to get medical reports from hospitals without a patient's permission or a court order.

The college said it had decided not to lay a charge of professional misconduct against the doctor, because among other reasons, he

had assumed wrongly, that the adjuster had obtained the consent.

NDP Leader Stephen Lewis, when told of the board's release, described it as incredible.

In hearings before the disciplines board, the doctor admitted he had no right to obtain the records from the hospital.

He said he had not acted in bad faith, having over the years prepared hundreds of similar reports, many of them for the same adjuster, assuming the adjuster had obtained the consent of the patient.

"This is incredible because it contradicts what the minister said in the House," Mr. Lewis said when told of the report.

"This is a very serious challenge to what the minister said in the House and demands an immediate investigation," Mr. Lewis said.

He said that the minister now must do what he told the House earlier he had done with the Ontario Health Insurance Plan and suspend the releasing of any information from hospitals.

"My God...it is a breach of law," Mr. Lewis said.

He wondered whether the doctor had received pay from the adjuster for the services.

Sean Conway, Liberal health critic in the Legislature, called the revelation shocking.

"This is the most serious challenge we've seen yet under the minister's control," he said. "There had better be a good explanation or there should be a full investigation."

Mr. Conway said it was an example of sloppy practices in the medical profession and might well be the same situation that has existed at O.H.I.P.

Liberal Leader Stuart Smith said he wanted to read the judgment and find the relationship between the adjuster and the doctor, and how widespread the practice is.

The report from the disciplines board said it concurred with the decision of the college in not laying a charge of professional misconduct, but to caution the doctor.

The board said the doctor had told it that he had obtained X-rays from the hospital in question.

"The board believes this may constitute a violation of the Public Hospitals' Act and recommends the matter be investigated by the appropriate authorities," the board says in its report.

The board also said the college made two attempts to find out from the adjuster whether the adjuster had tried to get consent from the patient.

"The board believes the adjuster exhibited a serious lack of responsibility in refusing to co-operate with the college in providing this information," the report says. The college hearing was held last June. -- CP

Dr. Porter did not advise his superiors at OHIP of the proceedings before the Complaints Committee and Health Disciplines Board prior to the publication of this newspaper story on November 30, 1977. On December 1, 1977, Dr. Porter disclosed to Gordon Fetherston, the general manager of OHIP, that he was the physician referred to in the newspaper article. Before November 30, 1977, neither the Honourable Dennis Timbrell, the Minister of Health, nor any other member of the Ministry of Health knew that Dr. Porter had been involved in a hearing before the Complaints Committee and the Health Disciplines Board, and moreover, did not know of Dr. Porter's unauthorized review of the medical records at the North York Branson Hospital.

As a result of the disclosure to Mr. Fetherston, David Buchanan, the manager of hospital claims at OHIP, was appointed to hold an internal hearing, to determine whether Dr. Porter had breached any obligation of confidentiality and whether he was in

breach of existing Ministry regulations in failing to disclose his outside employment by insurers and adjusters to the Deputy Minister of Health.

The hearing was held on December 12, 1977, at which time Dr. Porter again stated that his unauthorized review of M's North York Branson Hospital records was an isolated incident. At our hearing, Dr. Porter admitted that he had not informed Mr. Buchanan that he had made unauthorized reviews of hospital records on other occasions. Just as the Complaints Committee and the Health Disciplines Board had done, Mr. Buchanan accepted Dr. Porter's representations that the case of M was an isolated incident. He made the following findings:

1. That there was no indication that Porter used his position as Medical Consultant to the advantage of his outside work;
2. That Porter's extracurricular activities until 1976 was such that he could have derived personal benefit from the OHIP medical claims information to which he had access as a Medical Consultant; and
3. That his outside duties ought to have been disclosed to the Deputy Minister, as required by Section 33(3) of the Regulations under The Public Service Act.

Mr. Buchanan went on to make these recommendations:

1. Dr. Porter be reprimanded for failing to advise the Deputy Minister as required by the Public Service Act.
2. That the Conflict of Interest section of the Regulations be brought to the attention of all Senior staff with access to health information.
3. That Management employees of OHIP be required to state that they have no outside work that is in conflict as defined in Section 33 of the Regulations to the Public Service Act.

Dr. Porter intentionally deceived the Complaints Committee, the Health Disciplines Board and Mr. Buchanan, all of whom believed Dr. Porter's representations that his review of the

North York Branson Hospital's records, without M's authorization, was an isolated incident caused by Dr. Porter's misplaced and naive reliance upon Mr. Lander, who had misled Dr. Porter into believing that M had authorized the review. As I have already said, this was patently untrue by Dr. Porter's own admission in his testimony at our hearing. I can in no way be critical of the decisions of the Complaints Committee, the Health Disciplines Board and Mr. Buchanan in the light of the misrepresentations made by Dr. Porter to them.

Report on August L

August L was a pedestrian who had been struck on January 23, 1976, by a motor vehicle insured by the Zurich Insurance Company. Mr. Lander's recollection was that he had received oral instructions from that insurance company to retain Dr. Porter. He then telephoned Dr. Porter and advised him of the particulars of the matter. During the telephone conversation no reference was made to possession by Mr. Lander of an authorization signed by August L to permit the release of health information. It was implicit in this conversation and retainer that Lander did not have such an authorization and that Dr. Porter knew that he did not have one.

Dr. Porter went to North York Branson Hospital where he examined August L's x-rays and chart. He inspected the chart at the nursing station. He could not recall whether a nurse was present or not, but in any event, he neither disclosed to anyone that he was acting for an insurer adverse in interest to August L, nor sought permission from anyone in authority before reviewing the chart. He testified that if a nurse had not been present he would have helped himself to the chart and that if a nurse had been present he would have identified himself simply as Dr. Porter. More surprising to me was his evidence that on visits of this kind, Dr. Porter would put on a hospital or a lab coat if one were available in the cloak room. He was uncertain whether he was wearing a lab coat during this visit. It would be understandable and reasonable for any nurse confronted by a "Dr. Porter" in a lab coat to infer that the doctor was carrying out a legitimate function and it is equally clear that Dr. Porter's purpose whenever he was so dressed was to cloak the surreptitious reason for his attendance.

In due course, Dr. Porter forwarded to Mr. Lander a written report, dated February 1, 1976, which contained substantial health information obtained from the records of North York Branson Hospital without August L's consent. The report, in part, read as follows:

...he was taken to the Emergency Department of the North York Branson Hospital where he was initially examined and assessed by the doctor on duty. Because of his injuries, he was admitted to the hospital and has been a resident therein ever since.

On arrival at hospital, it was determined that Mr. L's main injuries were confined to his abdomen and pelvic area. X-rays of the pelvis and upper leg areas revealed the presence of a non-displaced fracture of the left ischium at the junction of the ischium with the inferior pubic ramus. Because of the extent of his injuries and the incapacity associated therein, it was necessary to admit Mr. L to hospital. Mr. L was admitted under the orthopedic care of Dr. C an orthopedic surgeon on the staff of the North York Branson Hospital.

The type of fracture incurred by Mr. L was due to direct trauma to and pressure on the outer side of the pelvic area. It would appear that extreme pressure was exerted on this area with resultant depression of the acetabular area. There was no fracture of the acetabulum itself or of the femur. An area of bone had been depressed into the pelvis. Treatment of this fracture has been performed through the application of traction on the femur. This traction, I understand, is of skin only and not the skeletal variety. I understand that this traction has been successful possibly not in reducing the fracture but at least immobilizing it.

Since his admission to hospital, Mr. L has demonstrated some haematuria, lower pelvic pain and an elevation of temperature. Genital urinary investigation did not reveal the presence of any traumatic laceration through the genital urinary system. It is believed that the haematuria is due to trauma to the urethra or bladder without any disruption of internal lining. However, during this investigation it was noted that Mr. L had a somewhat enlarged, firm,

prostate gland. Dr. C has arranged for Mr. L to be investigated by a urologist to determine the abnormality, if any, of the prostate gland. This condition has no connection whatsoever with the accident and can be considered incidental to the accident only...

Zurich Insurance Company paid Dr. Porter \$75.00 for this report. Dr. Porter was prepared to attend at the Branson Hospital again if Mr. Lander so wished. His report made this clear in saying:

I believe that further information can be obtained from time to time if this seems to be necessary. If Mr. L is not discharged from hospital by the latter part of February, then a further investigation should be carried out to find the reasons why.

By letter dated March 2, 1976, Mr. Lander reported to Zurich Insurance Company and enclosed Dr. Porter's report. This letter stated, in part:

It is also interesting to note that Dr. Porter believes that some of the other "complications" that are indicated may have nothing to do with the accident in question and this will be checked closely and it will definitely effect the value of the claim both in regard to general damages and OHIP's subrogated interest.

Mr. Lander, however, never considered whether Dr. Porter could have been involved in a conflict of interest because his belief might have formed the basis for reducing OHIP's subrogated interest.

On April 21, 1976, Zurich Insurance Company authorized Mr. Lander to retain Dr. Porter again to obtain more recent medical information. Again Mr. Lander knew that August L had not executed an authorization to permit Dr. Porter to review his health records. That this is so was made clear in a letter dated June 1, 1976, from Mr. Lander to Zurich Insurance Company which, in part, read as follows:

This is further to my last report of April 5, 1976, and will confirm subsequent telephone conversations with you.

It was agreed that it would be beneficial to the file if we were to arrange for Dr. Porter to make further discreet enquiries with respect to the T.P. and his recovery situation since Dr. Porter's initial investigation as outlined by his report which you have on file. [emphasis added]

I have contacted Dr. Porter to arrange for a supplementary report of his enquiries and investigations and as soon as this has been received it will be forwarded to you. There will however be a short delay due to the fact that Dr. Porter is on an extended vacation and is not expected back for another 2 weeks. As soon as I have Dr. Porter's further report it will be forwarded to you for your file and we will then be in a position to assess the T.P.'s injuries, consider file reserve, etc., etc.

As it happened, Dr. Porter did not, in fact, prepare a further report because on July 19, 1976, a decision was made not to obtain another report. That decision, however, was not, in any way, based upon a recognition that the retaining of Dr. Porter was improper.

Once again, it is clear to me that Zurich Insurance Company authorized the initial retaining of Dr. Porter in the expectation and knowledge that Dr. Porter would obtain medical information without the patient's authorization and that on June 1, 1976, it was prepared to retain Dr. Porter to obtain further health information without August L's authorization.

Report on G

On June 19, 1976, G was a pedestrian who had been struck by a motor vehicle insured by The Insurance Company of North America, commonly known as INA. Ben Venutto was the claims person at INA responsible for dealing with this case and he assigned the adjusting of this claim to Lander-Spiers Insurance Adjusters Ltd. Mr. Lander immediately learned that G had retained a solicitor and that he would be unable to obtain G's

authorization to release medical information. In accordance with what he described as his usual procedure, Mr. Lander then spoke to Mr. Venutto and received INA's authority to retain Dr. Porter. Mr. Lander disclosed to Mr. Venutto that he was neither in possession of, nor likely to receive, G's authorization to release medical information. INA therefore knew and sanctioned the retaining of Dr. Porter to obtain medical and health information without G's authorization. On July 23, 1976, Mr. Lander telephoned Dr. Porter at the OHIP Mississauga office, eventually spoke to him, and asked him to obtain particulars of the extent of G's injuries.

Dr. Porter went to North York Branson Hospital with the intention of physically examining G. G, however, had been discharged with the result that Dr. Porter was only able to review the x-rays and radiological reports. He did not review the remainder of G's hospital records. He prepared a written report, dated August 9, 1976, and submitted his account for \$75.00 with it. In due course, that account was paid by INA. The report contained the following substantial medical information:

Following the incident, Mrs. G was taken to the Emergency Department of the North York Branson Hospital, here she was initially examined and assessed by the doctor on duty and I believe most of her injuries were confined to the knee area. X-rays were taken of the knee and these x-rays revealed the presence of a comminuted fracture involving mainly the medial tibial plateau. There was no significant displacement of the bony fragments. However, because of the larger size of the bony fragment it was considered advisable that this fragment be surgically anchored to the remaining tibia in order to assure an optimum result.

Mrs. G was subsequently operated on by Dr. M, an orthopedic surgeon on the staff of the North York Branson Hospital. A total of three wires were placed across the fracture site and, in this way, the fracture was satisfactorily reduced and immobilized.

When he went to North York Branson Hospital, Dr. Porter knew that Mr. Lander did not have an authorization from G, which would have permitted him to examine the hospital records. At no time did Mr. Lander, expressly, or implicitly, ever represent to

Dr. Porter that he was in possession of an authorization. In his evidence, Dr. Porter said that whenever he spoke to any adjuster, if no mention was made of an authorization, he assumed that the adjuster had one. This, to me, is an astonishing proposition which has no relationship to reality. It was again implicit in the discussion between Dr. Porter and Mr. Lander that Mr. Lander did not possess an authorization signed by G, that he could not obtain one, and that it was for these very reasons that Dr. Porter was retained. Dr. Porter knew that to be the case. In his testimony, Dr. Porter said that he was:

... shocked to disbelief almost that
Mr. Lander had only retained me on those
occasions in which he did not have consent.

I cannot accept this statement. When he attended at North York Branson Hospital, he did not inform any of the hospital personnel of the fact that he was representing Mr. Lander or an insurance adjuster who was in an interest adverse to that of G. He did not disclose that he did not have G's written authorization. After learning that G had been discharged, he did not suggest to Mr. Lander that the written authorization be produced and all the medical records reviewed so that he might give a precise opinion and prognosis. Dr. Porter did none of these things, all of them things which a person acting in the honest belief that his attendance was with G's authority would do, because, in fact, he knew perfectly well that he had been retained precisely because Mr. Lander could not obtain G's authorization.

Summation of Mr. Lander's Involvement

Mr. Lander testified that he had retained Dr. Porter to obtain health information from hospitals and to carry out physical examinations of patients, both without authorizations, on approximately five occasions in the period before April 27, 1974, the date of earliest report discovered by our investigation. In all of the cases involving Mr. Lander, Dr. Porter knew that the injured patient had not signed an authorization which would have permitted the release of health information. Mr. Lander retained Dr. Porter precisely because there was no such authorization since he believed that Dr. Porter would be able to attend at hospitals and obtain the desired health information without an authorization. Mr. Lander was frank to admit that he did not care how Dr. Porter obtained the information. I am satisfied that he knew that Dr. Porter was acting improperly and that he continued to retain him to carry out these improper activities. I accept Mr. Lander's statement that

he did not know of the precise applicable statutory prohibitions. Mr. Lander intended Dr. Porter's reports to be kept secret and not to become known to the patients or their solicitors because he believed that Dr. Porter's activities, and his own involvement, in obtaining this medical information without authorization was "wrong".

Report on P

Michael Spiers, who was, along with Lawrence Lander, a principal shareholder in Lander-Spiers Insurance Adjusters Ltd., was also a knowledgeable and experienced adjuster familiar with personal injury cases. Mr. Spiers became aware of Dr. Porter in or about the year 1973.

P was a pedestrian who had been struck on July 31, 1976, by a motor vehicle. David Tune and Associates referred the adjusting of this claim to Lander-Spiers Insurance Adjusters Ltd., by whom Ray Shaw was employed at the time of this assignment. He held a probationary adjuster's licence, which required either Mr. Lander or Mr. Spiers to sign reporting letters to the company's principals. Because Mr. Shaw was an experienced insurance adjuster, and probationary only in the sense that he had recently returned to the insurance adjusting field, he had his employer's authority generally to deal with the adjusting of claims. Mr. Shaw retained Dr. Porter to obtain medical information about P because P absolutely refused to sign an authority to release medical information. That this is so is made clear in the report, dated November 12, 1976, signed by Mr. Spiers, but prepared by Mr. Shaw, to David Tune and Associates:

As claimant absolutely refused to sign any authority for medical information we therefore contacted John M. Porter, M.D. to obtain as much information as possible.

Enclosed is the Doctor's report, which is confidential along with his account for services and we would recommend payment as follows: John M. Porter - M.D. - \$75.00.

Mr. Spiers admitted that, in November, 1976, he knew that it was improper for a physician to inspect hospital records without the patient's authority and without the hospital's knowledge. He made no mention of this, however, to David Tune and Associates or to Mr. Shaw. Mr. Spiers testified that it was the policy of his company to obtain express authorization from its principals before incurring the cost of a medical report,

but there were no documents in the company's file confirming that authorization from David Tune and Associates had been sought before Dr. Porter was retained.

Dr. Porter went to the x-ray department at St. Joseph's Hospital in Toronto, without P's written authorization. He presented himself at a clerical wicket and asked for P's x-rays, identifying himself as Dr. Porter. He did not reveal that he was neither P's attending physician nor a member of the St. Joseph's Hospital staff. He reviewed the actual x-rays. He did not go to the medical records library because he knew that he would be refused access to the records there without production of P's authorization. Dr. Porter's evidence was that he believed that Mr. Shaw had obtained P's authorization to the release of information but he had no express recollection of this conversation with Mr. Shaw and could not swear that Mr. Shaw had actually so informed him.

His approach to the x-ray department instead of the medical records department makes Dr. Porter's conduct suspect. If Dr. Porter honestly had believed that Mr. Shaw actually had possession of such authority he could have asked for its production. This would have enabled him to have access not only to the x-rays but also to the entire medical records which would have provided him with substantial information upon which he could then have based an informed opinion. On this issue, too, I reject Dr. Porter's statement that he believed that Mr. Shaw had P's authorization. I am entirely satisfied that Dr. Porter actually knew that he did not have P's permission and that that was precisely why he was retained.

In an extract from his report, dated August 11, 1976, Dr. Porter wrote:

Following the incident, Miss P was taken to the Emergency Department of St. Joseph's Hospital, Toronto, where she was initially examined and assessed by the Doctor on Duty.

To the best of my knowledge, I understand that the most severe injuries sustained by Miss P were to her pelvis and to her left leg. X-rays revealed the presence of a fracture of the superior ramus and a fracture of the inferior ramus of the right pubic bone. These fractures were at the junction of the pubic and ischial bones and were not displaced to any degree. There was

noted to be a fracture at the inferior aspect of the right iliac bone adjacent to the sacral iliac joints with diastasis of this joint. The fracture line extended to the posterior iliac crest.

There was also noted to be an avulsion fracture of the left tibial spine and this fracture may have associated with a tear of the cruciate ligaments.

I have no record as to whether Miss P sustained any further injuries. However, because of her early discharge from hospital I would think that there were none of any import.

Because of the location of the injury within the left knee joint, it was considered advisable to reduce and immobilize the fracture fragment by surgical means. For this reason, on July 16, 1976, Miss P underwent surgical repair. This consisted of driving a pin through the fracture fragment into the upper end of the tibia in order to reduce the fracture and immobilize the fragment. I have no knowledge as to whether any ligamentous repair was necessary and undertaken at any time.

Miss P made an uneventful recovery from this surgical procedure and she was discharged from hospital on July 30, 1976, to the Hillcrest Convalescent Hospital. I have no further information as to her state of health since she was admitted to the Hillcrest Hospital.

It should be noted that I did not at any time discuss these injuries with Miss P nor did I have the advantage of examining her personally.

It was Mr. Spiers's responsibility to supervise Mr. Shaw both as an employee of his company and as a probationary adjuster. Mr. Spiers knew or ought to have known that Mr. Shaw intended to retain Dr. Porter. He also knew or ought to have known that P would not sign an authorization to permit the release of medical information and that it was for precisely

this reason that Dr. Porter was retained. He knew that, from time to time, Mr. Lander had retained Dr. Porter to obtain medical information when the claimant would not sign an authorization. Mr. Spiers knew this was improper and did nothing to end the practice.

David Tune and Associates were represented by counsel at our hearing. Although it had the opportunity to call evidence, as did any party represented, David Tune and Associates failed to do so and thus failed to rebut the inference that it had prior knowledge of Dr. Porter's retainer. As a matter of general business practice, Lander-Spiers Insurance Adjusters Ltd. obtained the authorization of a principal before committing itself to such an expenditure as \$75.00 for a medical report. This is understandable when one realizes that in some cases the fee for the complete adjusting of a claim might be as low as a total of \$250.00. I believe that the firm of David Tune and Associates was contacted and authorized the retaining of Dr. Porter, and, moreover, that it knew that P had not signed any authorization permitting the release of medical information when Dr. Porter's retainer was authorized.

Dr. Porter

Dr. Porter's testimony took three and a half days. On the important issues about which he testified, he was, in my opinion, intellectually dishonest and the explanations which he gave for his actions were unworthy of belief. Throughout the period during which Dr. Porter was conducting himself in the manner I have described there was in effect a provision in Regulation 749, made under the authority of The Public Service Act, R.S.O. 1970, chapter 386. This provision was drawn to the attention of employees of the Ministry in November, 1973, by a memorandum from the Deputy Minister of Health. As amended by section 2 of O. Reg. 605/73, section 33 of Regulation 749 deals with the subject of conflict of interest and reads as follows:

33. (1) A public servant shall not engage in any outside work or business undertaking,

(a) that interferes with the performance of his duties as a public servant;

(b) in which he has an advantage derived from his employment as a public servant;

- (c) in which his work would otherwise constitute full time employment for another person; or
- (d) in a professional capacity that will, or is likely to, influence or affect the carrying out of his duties as a public servant.

(2) Whenever a public servant considers that he could be involved in a conflict of interest in that he might derive personal benefit from a matter which in the course of his duties as a public servant he is in a position to influence, he shall disclose the situation to his deputy minister, agency head or minister, as the case may be, and shall abide by the advice given.

(3) Whenever a public servant considers that he could be in a position of conflict with the interests of the Crown arising from any of his outside activities, he shall disclose the situation to his deputy minister, agency head or minister, as the case may be, and shall abide by the advice given.

(4) Contravention of any of the provisions of subsection 1 or disregard of the provisions of subsection 2 or 3 may be considered as cause for dismissal.

In the face of this provision, and without the permission of the Deputy Minister, Dr. Porter accepted employment from adjusters and insurance companies. He knew that OHIP had the right of subrogation against a wrongdoer, that is, the right to recover from the insurer of a wrongdoer the costs of hospital and medical care incurred by or on behalf of an injured person as a result of the wrongdoer's negligence. He knew that an opinion given by him that the need for hospital or medical care was not the result of the insured person's negligent act would affect OHIP's right of subrogation.

Dr. Porter's report of February 1, 1976, with respect to August L contains these sentences:

Since his admission to hospital, Mr. L has demonstrated some haematuria, lower pelvic pain and an elevation of temperature. Genital urinary investigation did not reveal the presence of any traumatic laceration through the genital urinary system. It is believed that the haematuria is due to trauma to the urethra or bladder without any disruption of the internal lining. However, during this investigation it was noted that Mr. L had a somewhat enlarged, firm prostate gland. Dr. C has arranged for Mr. L to be investigated by a urologist to determine the abnormality, if any, of the prostate gland. This condition has no connection whatsoever with the accident and can be considered incidental to the accident only. [emphasis added]

Mr. Lander's letter of March 2, 1976, to Zurich Insurance Company, transmitting Dr. Porter's report, contains the following clear illustration of the conflict-of-interest problem:

As Dr. Porter points out in his report there is the obvious danger of future problems for this man in view of his advanced age and the matter will require close observations. Depending on future developments it may be wise to arrange for Dr. Porter to make further enquiries some time in March if the third party is still at the hospital. It is also interesting to note that Dr. Porter believes that some of the other "complications" that are indicated may have nothing to do with the accident in question and this will be checked closely and it will definitely effect the value of the claim both with regard to general damages and O.H.I.P.'s subrogated interest. Attached is Dr. Porter's account for services rendered and the following cheque would be appreciated as soon as possible. [emphasis added]

Dr. Porter maintained that he was unaware of these conflict of interest guidelines. I am prepared to believe that he may have been unaware to their precise terms and extent. However, because of his own admission, I am sure that he knew that his opinion could effect OHIP's right to recover. I am equally certain that he knew that in accepting such work, he would

ultimately find himself in an actual conflict-of-interest position in which his opinion would effect the right of recovery of his employer. Despite this knowledge, he persisted in accepting the retainers offered by adjusters and insurers.

On the other hand, I am satisfied that Dr. Porter did not inspect OHIP records for any improper purpose but examined them only with relation to matters properly within the scope of his duties.

I have already referred to Dr. Porter's astonishing admission that on occasion, when, for the purposes I have discussed, he went to hospitals in which he had neither active nor courtesy privileges, he would go to the physician's cloak room and put on a lab coat if one were available. He denied, however, that dressing himself in this way was a means of disguise intended to lead the hospital staff and patients to believe that he had a legitimate purpose at the hospital. He boldly claimed that, in wearing a lab coat in these circumstances, he was following "rules and regulations" and that there was no ulterior motive in his so doing, even though his attendance was for the purpose of reviewing hospital records or carrying out a physical examination without patient authorization. His incredible position is set out in the following exchange at our hearing:

MR. KESTENBERG [counsel for York-Finch General Hospital]: You also stated that with respect to some of the hospitals, although I believe you could not recall which specifically, you followed the rules and regulations of wearing a lab coat when you attended at the hospital?

A. I think I stated if a lab coat was provided, by and in the hospital in the doctors' cloak room if you like, or some other area, yes, I wore it.

Q. Would not the doctors' cloak room be a cloak room designated specifically for doctors on staff or doctors with privilege at the hospital?

A. No, it would not.

Q. It would be for any doctor that might visit a patient or a friend or just happen to be in the hospital?

A. Yes. That would be my understanding.

Q. And the requirement...

MR. COMMISSIONER: Is that really your understanding?

A. Yes, sir.

MR. COMMISSIONER: In a given hospital the physicians' staff room or the physicians' lounge or the physicians' cloak room is intended for the profession at large? Anybody who is a doctor anywhere or just in Ontario?

A. No, I think the staff room is the, the doctors' cloak room and the doctors' staff room is primarily put there for the benefit of the doctors on the staff because they are by and large...

MR. COMMISSIONER: Not primarily. I'm asking, for example, suppose a visiting physician from Afghanistan came to visit a patient in the hospital. Would he be entitled to go to the place where the lab coats are kept?

A. Not only entitled, I think he would be probably directed to that. In other words, if I went to the hospital and asked where I should hang my coat or where I should go, they would direct me to the doctors' cloak room.

MR. COMMISSIONER: Any hospital? If you went to visit a friend or a relative, they would direct you to the doctors' cloak room?

A. Oh yes, if I inquired what I should do, yes.

MR. COMMISSIONER: This would be true of any doctor licensed anywhere in the world?

A. I would think so, sir. Again, I would see no reason they would not.

Perhaps the absurdity of Dr. Porter's answers is self-evident but, at the risk of redundancy, I characterize them as answers which call into question or, at least, call for the need carefully to weigh, the reliability of any of Dr. Porter's statements. When asked, hospital administrators who gave evidence at our hearings rejected, without hesitation, the notion that "any physician", no matter whether he or she enjoyed staff hospital privileges might utilize a cloak room provided by the hospital for physicians, put on a lab coat, the property of that hospital, and wander the hospital's halls in a lab coat as a matter of custom or invitation. There can be no doubt that Dr. Porter's use of a lab coat in the circumstances described was a disguise intentionally adopted by him to induce in hospital employees and professional staff the belief that his attendance at the hospital was for a legitimate purpose, or, at the very least, to prevent any suspicion that he was there for any other kind of purpose.

Dr. Porter was unconcerned, when at these hospitals, that he might be detected in the course of attempting to obtain information from medical records. In his employment at OHIP he attended at hospitals from time to time. He had in his possession identification bearing the insignia of the Province of Ontario and showing him to be both a physician employed by OHIP and a coroner. Although there was no evidence that Dr. Porter ever used his identification cards to create the impression he was in the hospital for official business when he was, in fact, improperly obtaining health information without patient consent, I am sure that he would not have refrained from doing so if he had been asked to explain his presence.

Dr. Porter was seen by the chief x-ray technologist at the North York Branson Hospital, Richard Clarence Kruger during the years of 1972 and 1973 on at least two occasions looking through the key cards which identified x-rays relating to a patient in whom he was interested. There is no index in the x-ray department of that hospital which indicates whether a former patient is alive or dead. Mr. Kruger had known Dr. Porter as a coroner and believed him to be on coroner's business and therefore did not challenge him or question his purpose. Dr. Porter testified that he has done no coroner's work since May, 1971. If that is true, he must have been seeking medical information without authorization for an adjuster or insurer when Mr. Kruger saw him in the x-ray department. In short, I am satisfied that Dr. Porter discounted the possibility of detection because the scope of his employment and identification provided a perfectly rational explanation for him to use if he had been challenged or questioned while carrying out his improper activities.

In his evidence, Dr. Porter said that he personally accepted as fundamental ethical principles,

- (1) that every physician had an obligation to keep information about a patient confidential unless the patient consented to the disclosure of such information or unless the disclosure was required by law;
- (2) that, despite this general obligation of confidentiality, a physician could, without a patient's consent, disclose that patient's medical information to a fellow physician;
- (3) that it was the ethical responsibility of the physician to keep in confidence any information which he might obtain from a fellow physician about a patient who did not consent to the disclosure of that information to him;
- (4) that boards of trustees of public hospitals had an obligation not to permit persons to remove or receive information from medical records unless there was compliance with section 48 of Regulation 729, made under The Public Hospitals Act;
- (5) that it was improper for a physician, retained on behalf of an insurer of someone opposed in interest to the person to physically examine a person unless that person clearly understood the physician's role and that the physician had a duty to explain fully that the physician was retained on behalf of the insurer of the other party.

It is my view that a physician must not disclose information about an identifiable patient without the patient's consent to a fellow physician who is not involved in the patient's care. Dr. Porter's principles (2) and (3) had no validity. A physician, simply by virtue of membership in the medical profession, and without any relationship to a patient, has no special status in our society and stands in no higher position than any other

stranger to the patient with respect to the patient's right to the confidentiality of his or her medical information.

Dr. Porter made the unqualified admission that he had induced treating physicians to disclose to him health information about patients without the patients' consent. He admitted that, in from six to twelve cases other than those before the Commission, he breached what he, himself, considered to be his ethical responsibility and delivered particulars of this information received from treating physicians to adjusters and insurers whose interests were adverse to those of the patients. Dr. Porter's role in OHIP was an adjudicative one. He had the power to allow treating physicians who submitted accounts to OHIP a sum in addition to the usual sum set out in the fee schedule as independent consideration. He was, one may conclude, a person whom the physicians of the Mississauga district would not want to offend and it would not be unreasonable to wonder whether his position might not discourage a treating physician from fulfilling his ethical obligation to reject Dr. Porter's request for information about a patient.

Dr. Porter admitted that he reviewed hospital records and made notes from them without the patients' consent, and without any right of access to them and that he did this with actual knowledge that his conduct was unethical. He also admitted that, with knowledge of the impropriety of doing so, he carried out physical examinations of persons without disclosing that he had been retained by an insurer adverse in interest and without fully explaining his role. It is an understatement to say that the conduct of Dr. Porter which I have described was conduct unbecoming a member of the medical profession in Ontario or conduct which the public expects would reasonably be regarded by members of the medical profession as disgraceful, dishonourable or unprofessional.

Upon the completion of his evidence at our hearing, on the 1st day of May, 1978, Dr. Porter submitted his resignation to OHIP. It was, of course, accepted.

After knowledge of Dr. Porter's extra-curricular activities became public, his professional misconduct became the subject of consideration by the Discipline Committee of The College of Physicians and Surgeons of Ontario. The misconduct in question involved four of the cases examined at our hearing. The Annual Report of the College, dated July, 1979, but released in October, 1979, contained the following account of the Discipline Committee's proceedings:

Dr. John M. Porter

Dr. Porter was charged with professional misconduct. It was alleged that he, at various periods in 1976, gave information concerning four hospitalized persons to third parties without obtaining proper consent of the patients to do so. After evidence and arguments the Discipline Committee found that Dr. Porter, in the case of each patient, prepared a report for a firm of insurance adjusters who had retained him for this purpose. In each case he was paid a fee.

The medical records were prepared from documents including x-rays obtained from Branson, St. Joseph's or York Finch Hospitals. Dr. Porter was not on the staff nor did he have hospital privileges at any of those hospitals. None of the patients had ever consulted Dr. Porter and his only knowledge of them was via the hospital records.

In addition, Dr. Porter never obtained a consent to the release of medical information from any of these persons. Nor had he been shown a consent obtained by anybody else. In fact, consent had not been given.

After deliberation the Committee was satisfied with respect to each of the four cases that there was in fact no consent and that Dr. Porter did not take reasonable steps to satisfy himself that consent had been given. The Committee accepted that the view that the restriction on the release of medical information without consent applied not only to a doctor's own patients but to medical information respecting other patients as well.

After hearing submissions with respect to penalty the Discipline Committee order that Dr. Porter be reprimanded.

I need express no opinion with respect to the appropriateness of the penalty imposed. After considering the particulars

of the conduct which have been given, the reader is in as good a position as I am to form a judgment on the question whether the punishment is commensurate with the gravity of the offending behaviour.

Hospitals

Public hospitals in Ontario are governed by boards elected or appointed in accordance with the authority under which the hospitals are created, established or incorporated. The board of every public hospital has an obligation not to permit any person to remove, inspect or receive information from its medical records except in the specified circumstances set out in section 48 of Regulation 729 of The Public Hospitals Act, R.S.O. 1970, chapter 378.

In these inflationary times every hospital in Ontario is operated within increasingly stringent budgetary limits and every board must allocate the moneys available as wisely as it can. A hospital board need only take reasonable measures to meet its obligation to protect the confidentiality of medical records. It would be unreasonable to require it to set up an elaborate security system which anticipates and protects every conceivable and imaginable risk of access, however remote. To do so would be a misallocation of resources and could well impair the hospital's ability to make available to the public essential health services of high quality.

Members of the medical profession have a duty to respect the confidentiality of their patients' health information. They also have a duty to respect the obligation of confidentiality of their fellow members of the profession and to refrain from any act which would induce or promote another physician to breach his or her obligation of confidentiality. Physicians also have an obligation to refrain from any act which would subvert or circumvent hospital boards' efforts to protect the confidentiality of their medical records. Surely the board of every hospital has a right to rely upon the integrity of members of the medical profession and to assume that every physician will abide by his or her ethical responsibilities and refrain from conduct which would lead to the failure to protect the security of medical records as contemplated by section 48 of Regulation 729.

Our thorough investigation revealed that Dr. Porter was the only physician in active practice today in Ontario who inspected medical records for the insurance industry without proper authority. The Insurance Bureau of Canada, commonly referred to

as the I.B.C., is the marketing representative of the insurance industry in Canada and represents private insurance companies who wrote in excess of four billion dollars of premiums in 1977. This premium dollar figure represents 95 per cent of the total general insurance premiums written by private insurance companies in Canada in the year 1977. The I.B.C., in response to my request, canvassed its member companies and reported through its counsel, R.F. Wilson, Q.C., that it was "unable to document any instance of any doctor currently in practice in Ontario who had obtained information in the manner ascribed to Dr. Porter."

Although I have reason to believe that in an earlier era other physicians in Ontario engaged in similar acts from time to time, I am satisfied that Dr. Porter is the only member of the medical profession who, in recent years, betrayed the trust reposing in him as a member of that profession. His conduct was a gross deviation from the standards observed by responsible members of his profession.

Dr. Porter violated the confidentiality of health records at the following hospitals:

1. The Toronto Western Hospital;
2. Queensway General Hospital;
3. Toronto General Hospital;
4. York-Finch General Hospital;
5. North York Branson Hospital;
6. St. Joseph's Hospital, Toronto.

I have concluded that, with respect to Dr. Porter's conduct, the boards of these hospitals and their employees acted reasonably and properly in their attempts to preserve the confidentiality of their medical records. Their records were improperly inspected, not because of any deficiency in security, but because Dr. Porter brazenly exploited a necessary trust by his outrageous conduct. The activities, practices and conduct of the boards of trustees of these hospitals, in the Porter affair, were, in my opinion, beyond criticism. It would, however, be reasonable for every hospital to require all their employees and persons with privileges in that hospital to wear an identification badge unique to that hospital. A measure of this kind would make it impossible for someone to pass himself or herself off as one who is entitled to access to patients and their records.

Recommendation:

2. *That all public hospitals require their employees and persons with practising privileges to wear an identification badge containing the wearer's name, position and photograph.*

CHAPTER 5

Centurion Investigation Ltd.

St. Catharines General Hospital Incident

On April 14, 1977, Mrs. Linda Montague, a medical record technician employed by the St. Catharines General Hospital, received a telephone call. The caller identified herself as being from the Toronto General Hospital and represented to Mrs. Montague that a patient, one J.M., was unconscious from a drug overdose in the Toronto General emergency department. The caller requested that Mrs. Montague obtain the hospital records of J.M. and provide her with J.M.'s medical history, particulars of J.M.'s hospital attendance and any other information on file. Mrs. Montague noted the caller's telephone number as 225-1486 and was advised by the caller that this was a direct dial number. Mrs. Montague told the caller that she would check J.M.'s chart and return the call. J.M. had been a psychiatric patient at the hospital and Mrs. Montague reviewed the chart. She was suspicious and thereupon checked the telephone directory listing and telephoned Toronto General Hospital to verify that 225-1486 was one of its phone numbers. Mrs. Montague was informed that 225-1486 was not a Toronto General Hospital telephone number and that J.M. was not being treated in that hospital's emergency department.

Mrs. Montague then dialed number 225-1486 and this call was answered "Mrs. Robinson, medical records department". Mrs. Montague told "Mrs. Robinson" that she had telephoned Toronto General Hospital and had been informed that J.M. was not in the emergency department. She was then told that she had misunderstood and that she was speaking to someone at the Toronto East General Hospital, and not the Toronto General Hospital. She displayed unusual perception and again said that she would return the call. Mrs. Montague obtained the telephone number for the Toronto East General Hospital, called that number and was advised that 225-1486 was not a number associated with the Toronto East General Hospital.

While Mrs. Montague was making this telephone call to the Toronto East General Hospital, another telephone call was received in the hospital's medical records library. The caller identified himself as Dr. Henderson, calling from the emergency

department of the Toronto East General Hospital. The recipient of this call told "Dr. Henderson" that there was difficulty in verifying the legitimacy of the request for information and requested that he wait a moment. "Dr. Henderson" became irate and warned that J.M.'s life was in jeopardy. Mrs. Montague, who was informed of the "Dr. Henderson" call, transferred from the hospital's medical records library to the emergency department. She learned that there was no Dr. Henderson on staff and that there was no J.M. being treated in the emergency department. Mrs. Montague reported this incident to her department head and faithfully recorded the sequence of events and the telephone number 225-1486. If it had not been for Mrs. Montague's perception and intelligence, we may never have discovered the abuses occurring in the investigation and insurance fields.

The Ontario Provincial Police Investigation

J. R. Barr, Q.C., the solicitor for the St. Catharines General Hospital, reported the particulars of this incident to the Ontario Provincial Police on May 14, 1977. That force, through its Registration Branch, is responsible for the regulation of the private investigation industry, under the provisions of The Private Investigators and Security Guards Act, R.S.O. 1970, chapter 362. The OPP investigation determined that Paragon Investigation Ltd. had been retained by The Wawanesa Mutual Insurance Company to carry out an investigation of J.M.'s medical condition. The OPP was unable to prove to its satisfaction who had made the call to the hospital although, as Staff-Sergeant Merlin Stroud testified, the OPP believed the call originated from Centurion Investigation Ltd.

Paragon Investigation Ltd. surrendered its licence. Acting Superintendent James Villemaire testified that the surrender of the Paragon licence did not end the investigation, which was still continuing on the date of our hearing, June 1, 1978. No member of the OPP reviewed Centurion Investigation Ltd. files to determine whether calls of a similar type had been made, despite the fact that the Act conferred the power to undertake such a review. The reason for the failure to carry out such a review has never been satisfactorily explained. I believe that, for all practical purposes, the surrender of the licence by Paragon Investigation Ltd. terminated the OPP investigation. Our investigation established that one or more of the McGarry brothers, the principals of Centurion Investigation Ltd., was or were the beneficial owner or owners of the issued shares of Paragon Investigation Ltd. More will be said of the McGarry brothers later. I am satisfied that Paragon Investigation Ltd. surrendered its licence in the hope, a hope that was realized,

that the surrender would terminate the OPP investigation and thereby protect from disclosure the practice by Centurion Investigation Ltd. of obtaining access to health records of claimants without their authorization.

Our Investigation of the St. Catharines General Hospital Incident

As part of our investigation, we carried out a survey of all public hospitals in Ontario to see if we could determine whether there had been, among other things, any attempts to obtain medical information without patient authorization. It was this survey that disclosed the St. Catharines General Hospital incident. In passing, I add that the OPP did not report this incident to us. Our investigation revealed that Paragon Investigation Ltd. had been retained by The Wawanesa Mutual Insurance Company to carry out an investigation of J.M., who had been injured in a motor vehicle accident. In turn, Paragon Investigation Ltd. retained Centurion Investigation Ltd. to obtain medical information about J.M. The records of Bell Canada showed that, on April 14, 1977, telephone number 225-1486 had been assigned to Centurion Investigation Ltd. and that on April 14, 1977, telephone number 225-1486 was changed, at that company's request, to telephone number 226-1704. Our examination of the OPP Registration Branch file on Centurion Investigation Ltd. disclosed that the OPP had investigated that company with relation to this incident. It also disclosed particulars of a complaint about another occasion on which Centurion Investigation Ltd. had attempted to obtain medical information without authorization. Our investigators attended at the Centurion premises with a search warrant and seized its files relating to the St. Catharines General Hospital and the second complaint, along with Bell Canada long distance toll sheets for telephone number 225-1486 and 226-1704. Calls to the St. Catharines General Hospital on April 14, 1977, were shown on the long distance toll sheets for telephone number 226-1704. Because telephone number 225-1486 had been changed on April 14, 1977, to 226-1704, the long distance charge appeared on the Bell Canada charge sheet produced at the end of April, 1977.

As a result of the information contained in the material seized and as a result of further information obtained by the Commission, a further search warrant was obtained and on April 19, 1978, 720 files of Centurion Investigation Ltd., relating to investigations undertaken from the 15th day of August, 1976, to the 1st day of March, 1978, were seized. An analysis of these files disclosed 362 files in which health information had been

requested or obtained. Health information was actually obtained in 286 of these files.

The Company and its Shareholders

Centurion Investigation Ltd. was incorporated in Ontario in 1972 and was licensed pursuant to the Act. At all material times, the shareholders were four brothers, John McGarry, who held approximately 50 per cent of the issued shares, Daniel McGarry, who held approximately 30 per cent of the issued shares, James McGarry, who held approximately 15 per cent of the issued shares, and Thomas McGarry, who held approximately 5 per cent of the issued shares. It will be recalled that one or more of the McGarry brothers owned the beneficial interest in the shares of Paragon Investigation Ltd.

Pretexts

A pretext is a misrepresentation, deception, ruse or trick utilized to cause a person to carry out or submit to an act or impart information. Pretexts are discussed in my consideration of the activities of Dr. John Porter elsewhere in this report. Before the fall of 1973, individual investigators employed by Centurion Investigation Ltd., of their own initiative, had used pretexts from time to time for the purpose of obtaining health information. The company itself had not developed a system by which health information was routinely obtained by the use of pretexts.

In the spring of 1973, Kieran Patrick McCarthy was employed by Centurion Investigation Ltd. as an investigator. About the month of September, 1973, Mr. McCarthy became director of field operations. His responsibility did not extend to the supervision of the insurance investigation work being undertaken by the company. That jurisdiction belonged to Daniel McGarry. During the fall of 1973, Mr. McCarthy and Daniel McGarry had several discussions relating to the use of pretexts. They knew that one of their investigators had been having substantial success in obtaining health information from hospitals and physicians' offices by the use of pretexts. That investigator was neither articulate, glib nor knowledgeable about medical terminology. Mr. McCarthy and Daniel McGarry concluded that substantial health information was passed within the medical community, as a matter of expediency, by telephone without any security precautions being taken to ensure that the person requesting and receiving the health information was acting legitimately. They concluded that this dialogue within the medical community was

carried out primarily by women, i.e., nurses, receptionists, technicians, and medical record librarians and that, therefore, a female voice would less likely arouse suspicion than a male voice when making a request for information.

Mr. McCarthy testified that Daniel McGarry and he considered the release of medical information to be an "ethical matter" for the physician as opposed to a legal matter. He stated that they had concluded that the "truth" was being hidden behind the ethics of the medical profession, that their client's right to know was in conflict with the right of the patient to privacy and that the right of their client to know was, on balance, more important than the patient's right. Mr. McCarthy went on to say that he had been unaware that there was a legal obligation upon physicians and hospital employees to keep information confidential. He acknowledged that an investigator had an obligation of confidentiality imposed by the Act with respect to information coming into his possession during the course of his duties. Because he is an intelligent and well informed person, I find it incredible that he did not realize that a physician had, at the very least, a similar legal obligation, although he may well have been unaware of the precise governing statutory provisions. I am of the same view with respect to Daniel McGarry. In any event, the company carried on a large business and had access to corporate solicitors who were in a position to define precise legal obligations. It appears that no legal opinion was sought. I believe that Mr. McCarthy and Daniel McGarry knew that, generally, physicians had an obligation of confidentiality and that health information could not be obtained from a hospital without the written authorization of the patient. I conclude that they consciously decided to implement a carefully organized system, the aim of which was to obtain health information without authorization of the patient. I reject the notion that this was done after a philosophical analysis of competing interests and a nice balancing of ethical positions and responsibilities. I believe that the system was instituted because Mr. McCarthy and Daniel McGarry knew that health information was a commodity which had a pecuniary value and could be sold to their clients at a large profit.

In the beginning, two non-professional female employees were given the sole responsibility of making pretext calls to hospitals and physicians' offices for the purposes of obtaining medical information. The assignment of these functions to these employees was made with the express knowledge of all of the McGarry brothers.

In August, 1976, a registered nurse, Jane Darlene West, was hired by Daniel McGarry expressly and solely to make pretext

calls. She was familiar with medical terminology and Daniel McGarry believed that this knowledge would make the pretext seem all the more reasonable and successful. Ruth Mendelsohn, a registered nurse, was employed by Centurion Investigation Ltd. in January, 1977. She believed that she was being hired as an investigator and was licensed as such. She did the usual investigator's work including surveillances for the first few weeks of her employment. She was introduced to Miss West who taught her how to make pretext calls to physicians' offices and hospitals. These pretext calls were referred to within the company as "Medicals". On more than one occasion Miss Mendelsohn asked James McGarry whether the making of "Medicals" was proper. His reply was that Centurion's lawyers had sanctioned this practice and Miss Mendelsohn accepted his answer. I heard no evidence that, in fact, a legal opinion to that effect had ever been given. Misses Mendelsohn and West made their pretext calls from the offices of Centurion Investigation Ltd. but the two non-professional investigators made their pretext calls from their homes.

Both Miss West and Miss Mendelsohn must have known from their professional training that the making of these pretext calls was improper. I accept Miss Mendelsohn's statement that she found the making of these pretext calls distasteful. She testified that she had to choose either unemployment or this distasteful work since no work as a nurse was available to her. Nonetheless, that choice ought not to have been difficult for a person with her professional training. She ought to have chosen not to work at all rather than become involved in the making of pretext calls.

The Centurion System

Instructions to Centurion Investigation Ltd. from its clients to carry out investigations were usually received by telephone although both The Wawanese Mutual Insurance Company and Co-operators Insurance Association (Guelph), now known as The Co-operators, used a preprinted form addressed to Centurion Investigation Ltd. which set out the nature of the investigation required. When Centurion Investigation Ltd. received instructions from a client, as a general rule, a written confirmation was mailed to the client so that there would be no dispute as to the nature of investigation services requested and to be carried out. Invariably, the written confirmation would contain the word "Medical" as part of the assignment to be carried out. The word "Medical", as I have already said, was used to convey the meaning that pretexts would be used to obtain health information

from sources such as hospitals and physicians' offices. One of the forms, a typical one, read as follows:

CENTURION INVESTIGATION LTD.

Client: Hartford Insurance

Assigned by: Mr. S. Seggie

Date: January 27th, 1977

Client's File#: 631KALT27166

Subject: 1) and 2)

Centurion File#: 4464-I

TO DO: 1) Medical 2) Confirm why left
employment and where working now?
3) Activities and 4) Any back-
ground.

Limitation:

This will confirm that we have received from your office an assignment in relation to the above-mentioned subject.

Yours truly,

CENTURION INVESTIGATION LTD.

J.T. McGarry

JTMc/cd

On receipt of a client's instructions an "assignment sheet" was completed. This sheet might be circulated among several investigators depending upon what the client had requested; for example, if a surveillance was to be carried out in addition to an attempt to obtain medical information without authorization, the surveillance would be carried out by a field investigator and the pretext calls by the employee whose function was limited solely to the making of such calls. Before a pretext call could be made to a hospital or physician it was, of course, necessary to know the name of the treating physician and the hospital which the patient had attended. The client sometimes provided this information, which was obtained quite properly in some

cases, for example, from the police report or from the patient himself who voluntarily provided particulars of medical treatment. Where Centurion Investigation Ltd. had not been provided with the necessary information it used various pretexts to discover the names of the treating physicians and hospitals. It is helpful to have a description of some of the more common of these preliminary pretexts.

Research Pretext

Centurion Investigation Ltd. had printed bogus survey forms headed "Traffic Injury Researchers of Canada". Traffic Injury Researchers of Canada was a fictional entity. As James McGarry testified, this fictional name was probably chosen because it closely resembled, in name, The Council of Independent Traffic Injury Researchers of Canada, which is a bona fide research organization. A Centurion investigator would call at the subject's residence and represent that he was conducting a survey on behalf of Traffic Injury Researchers of Canada. The answers to the questions would disclose any hospital attendances, names of treating physicians, whether therapy had taken place and other relevant information. I reproduce the form used in carrying out this pretext.

TRAFFIC INJURY RESEARCHERS OF CANADA

NAME _____	ADDRESS _____	PHONE _____		
Sex _____	Date of Birth _____			
Racial Origin _____	Height _____	Weight _____		
Complexion _____	Hair _____	Eyes _____		
Glasses _____	Contact _____	Hearing Aid _____		
Cane _____	Crutches _____	Cast _____		
OCCUPATION				
Place: _____	Address: _____	Type of Work _____		
Hours of work _____		How long _____		
Rate of Pay _____				
PARTICULARS OF ACCIDENT				
Date _____	Time _____	Visibility _____		
Weather _____	Road conditions _____			
Driver _____	Owner _____	Passenger _____		
Pedestrian _____	Witness _____			
VEHICLE OF INJURED PERSON				
Make _____	Model _____	Year _____	Prior condition _____	Damage to Vehicle _____
Present condition _____				
INJURIES				
TYPE _____				
Disabled _____	How long _____			

Present condition _____ Hospital _____
Admitted _____ Specialist _____ Therapy _____
How long _____
WHAT OCCURRED? _____
INSURANCE
Medical _____ Hospital _____ Collision

Public Liability _____
SAFETY PROCEDURES
Lap Belt _____ Shoulder Harness _____
PHYSICAL CONDITION AT TIME OF ACCIDENT
OK _____ TIRED _____ EXHAUSTED _____
DRINKING _____
LEGAL
Charges _____ Disposition _____
LOSS OF INCOME
Employment _____ Medical _____ Vehicle _____
Lawyer _____ Other _____ Prior accidents _____
Prior injuries _____ Post accidents _____
Post Injuries _____
ACTIVITIES _____
COMMENTS _____

Marketing Survey Pretext

The Neighbourhood Survey which purported to be prepared by Metro Marketing Services was another survey form. Metro Marketing Services was also a fictional entity. The survey forms were prepared in large quantities by or for Centurion Investigation Ltd. for use by its investigators. The investigator would visit the subject and represent that he was employed by "Metro Marketing Services" and was carrying out a neighbourhood survey. This ruse would gain the investigator access to the subject's home. Investigators, who were required to be glib, were able quickly to turn the conversation to the subject's injuries and the circumstances of the accident, for example, by making comment about the subject's limp, scarring or use of a cervical collar. During the conversation the investigator would elicit the name of the treating physician or physicians or the hospital, if any, in which the subject had received care. The following is the market survey used.

METRO MARKETING SERVICES NEIGHBOURHOOD SURVEY

NAME(s) _____ ADDRESS: _____ PHONE #: _____
Number in household: _____ Adults: _____
Children: _____ Usual Place for Shopping: _____
Groceries: _____ Day and Time for Shopping:

Clothing: _____ Drugs and Sundries: _____

What Approximate Weekly Amount is Allotted for Groceries? _____ Do you own: Freezer: _____
Car: _____ TV _____ Fridge/stove _____ If so, what make: _____ Would you be in favour of Charge Accounts in Chain Food or Drug Stores? _____ Do you participate in any Clubs or Organizations? _____ If yes, give names:

Any other social activities: _____
Do the children belong to any group organizations? _____ If yes, give names:

What Bank do you use? _____ Branch
TYPE OF DWELLING: House: _____

Apt./Flat _____ Townhouse: _____ Condominium _____

Boarding House _____ Do you rent? _____ Own? _____

Purchasing? _____ Name of Management Firm or Mortgagee: _____ Status: Married: _____

Single: _____ Divorced: _____ Widower(er): _____

Husband's Place of Employment: _____

Position: _____ Wife's Place of Employment: _____

Position: _____ Any other members of Family working: _____ Where: _____ Any other sources of income: _____ Do you feel a need for more adequate facilities in your Neighbourhood? _____ Shopping _____ Medical _____

Dental _____ Social _____

Signature of Interviewer: _____

OHIP Pretext

For this pretext Miss West, Miss Mendelsohn or another employee of Centurion Investigation Ltd. would telephone the subject and represent that she was employed by the Ontario Health Insurance Plan and that OHIP was undertaking an investigation or an audit and ask the subject to name all physicians whom the subject had visited within a specific period, for example, three months prior to the call, and the names of all hospitals attended during the period. Almost without fail, the use of this pretext gave the employee the names of treating physicians and particulars of any hospital attendances.

Centurion Files

Miss West and Miss Mendelsohn, as well as the other employees engaged in the same work, were equipped with tape recorders. Almost all of the pretext calls were tape-recorded. Every

Centurion file contained a work sheet. The work sheet had an area headed, PRETEXT, in which the pretext used was to be inserted. Every pretext call was transcribed. The file containing the transcribed notes, the work sheet and such information as the surveillance reports, if any, was delivered to James McGarry, Daniel McGarry, or Thomas McGarry, who dictated the report to Centurion Investigation Ltd.'s client. Once the report had been dictated, the transcript of the pretext calls and the work sheet were destroyed as a matter of course.

It was the evidence of James McGarry that this destruction was carried out as a matter of good housekeeping and to conserve filing space. I cannot accept this explanation. There was much irrelevant material in many files which could have been destroyed to conserve space but was not. Centurion Investigation Ltd.'s principals knew that the Ontario Provincial Police, under the Act, had the right to attend to review the files if they had received a complaint. If the work sheets and transcripts of the pretext calls remained in the files there was a risk that the practice would be exposed. I believe that the destruction of the transcripts of the pretext calls and the work sheets was carried out as part of a concerted effort to conceal the improper manner in which health information had been obtained. Several work sheets, by oversight, were not destroyed. These work sheets set out the pretext used to obtain information. Some of the notations were: "O.H.I.P. Pretext", "Dr. Martin-Neurologist" and "Mrs. Martin-O.H.I.P." The words "O.H.I.P. Pretext" referred to the pretext which I have already described. The words "Dr. Martin-Neurologist" meant that the caller represented that she was from the office of Dr. Martin, a neurologist, who was to see the subject by way of consultation and required background medical information. Miss Mendelsohn testified that the "Mrs. Martin-O.H.I.P." meant that the caller represented herself as Mrs. Martin from OHIP, when making the pretext.

James McGarry handed out the assignments to the investigators. Since he also dictated many of the reports to the clients, he received work sheets in the ordinary course. Miss Mendelsohn said that, as a matter of practice, she used the OHIP pretext and that she believed that James McGarry knew that she used this pretext. When James McGarry was questioned about the OHIP pretext, he answered that he had no knowledge of an OHIP pretext. Later he said that he had no recollection of any notation of an OHIP pretext on any work sheet. He would have objected to the use of such a pretext if he had been aware of it because if a subject became suspicious, he could complain to OHIP. In the case of the use of a fake institute or council there was no one to complain to.

At our hearing James McGarry was shown a work sheet that contained a reference to "O.H.I.P. pretext". The report to the client was prepared by Thomas McGarry and James McGarry believed that Thomas McGarry would not be shocked by the use of such a pretext. I do not believe James McGarry's denial of knowledge of the practice. I am satisfied that both Thomas McGarry and James McGarry had actual knowledge of the use by their investigators of the OHIP pretexts.

Health information was obtained from every imaginable source. No source was immune. Some of the sources were: physicians, physicians' employees, chiropractors, dentists, physiotherapists, teachers, principals, school nurses, occupational health personnel, all hospital departments including admitting, accounting, physiotherapy, medical records, outpatient records, emergency, x-ray and business offices, social workers, private laboratories, private x-ray clinics, police departments, the Employment and Immigration Department, finance companies, life insurance companies, pharmacists, clergymen, universities, lawyers, psychologists, adjusters, and casualty insurance companies.

Three hundred and sixty-two files of Centurion Investigation Ltd. were seized in our investigation. Space does not permit a verbatim recital of all the health information obtained. I will, however, deal with Centurion Investigation Ltd.'s larger clients and in so doing will illustrate the quantity of health information obtained without patient authorization.

The Co-operators

The Co-operators is a casualty insurance company whose head office is in Guelph. In Ontario, The Co-operators, in 1978, employed approximately 250 persons who were involved in the adjusting of casualty losses. The Co-operators was Centurion Investigation Ltd.'s best customer. The records seized disclosed 194 files in which The Co-operators had retained Centurion Investigation Ltd. and requested or received health information about claimants. That The Co-operators and its employees actually knew that Centurion Investigation Ltd. was obtaining health information without patient authorization in some improper way is beyond question. Health information was obtained on a widespread basis for The Co-operators' employees on their express instructions.

The receipt of this information had reached such proportions and was so routinely expected that on November 17, 1977,

Keith Routledge, an employee of The Co-operators wrote to Frank McKellar at The Co-operators' head office, in part, as follows:

...apparently Centurion, particularly in the London and Toronto area have been slipping in their ability to obtain medical information from hospitals. Increasingly I get the answer that nothing can be released without authorization of the person involved. For this type of information, I am being charged, in my opinion, an inordinately high fee for nothing. When you've had a chance to consider these points and taken whatever action you think is necessary I would be pleased to know what reply that I should be making...

A copy of this memorandum was delivered to Centurion Investigation Ltd. In response, James McGarry wrote to Frank McKellar, on December 1, 1977, in the following language:

Due to the increasing pressure in relation to information disclosures and O.H.I.P. information in general, we are finding it increasingly more difficult to obtain medical information and would inform Mr. Routledge that the same amount of time and effort is involved in trying to obtain information where there is none available, as in obtaining a full medical report, and the cost factor accorded to us through our sources, is the same.

To illustrate how much health information was obtained for The Co-operators, I chose, at random, three of the 194 files relating to The Co-operators. I shall set out the circumstances giving rise to these reports.

Report 4557

On September 26, 1976, a motor vehicle collision occurred in Sudbury. A motor vehicle insured by The Co-operators struck a motor vehicle in the rear causing damage and injury to the operator and passengers of that vehicle. There was no issue as to liability, that is, The Co-operators' insured was clearly negligent and totally liable for all damages which resulted from the collision. By letter dated October 4, 1976, a solicitor notified the adjuster engaged by the Co-operators that he had

been retained on behalf of the operator and passengers of the second vehicle. I shall refer to these persons as the claimants.

An internal memorandum, dated November 2, 1976, from a claims supervisor of The Co-operators, Northern Ontario Region, to head office, said that "liability in this instance appears to be clear cut." It went on to say:

Once _____ is out of Sick Children's Hospital, I would like to see Centurion Investigation assigned to develop what medical information they can from the hospital. In your instructions to them I would suggest you indicate this is all we are wanting at this time. Also, you might query them whether it would be possible to obtain, over the phone the same information on _____ from the Sudbury Memorial Hospital.

By letter dated September 5, 1976, the same claims supervisor instructed The Co-operators' independent adjuster employed as follows:

Please advise as soon as _____ has been released from Sick Children's Hospital in Toronto. We plan to use Centurion Investigation to assist us to develop medical information. I do not want to involve them in the file until _____ is released.

About March 2, 1977, an employee of The Co-operators instructed Centurion Investigation Ltd. to obtain medical information about the claimants.

By letter dated March 30, 1977, signed by James McGarry, Centurion Investigation Ltd. made the following report:

WEDNESDAY, MARCH 2, 1977

The investigator received case instructions from our office in regards to this investigation.

THURSDAY, MARCH 3, 1977 to SATURDAY, MARCH 5, 1977

During this time, the investigator made periodical observations and inquiries at the Claimants place of residence located at _____ and at Claimant No. 1's place of

employment INCO Limited in Sudbury, Ontario, but was unable to observe either Claimant or any activities.

During this time, the investigator disclosed that there are four members of the family presently residing at in Sudbury, Ontario.

The investigator was informed that Claimant No. 2 has been crippled from birth due to a calcium deficiency in the bones which affects her legs and they are immobilized and the only way she can get around is with a wheelchair.

The investigator was further informed that she is presently attending public school and is able to participate in basketball and she is considered to be very well adjusted.

The investigator further disclosed that the fourth member of the household is the son who is and a student of where he is taking a course.

Claimant No. 1, , whose approximate age is years, is presently employed in the construction for INCO and works down in the mines.

The investigator was also informed that Claimant No. 1 is actively involved in the Mine Athletic Association for INCO and organizes holiday parties for miners and also funds and charities although he is not actively involved in sports.

Claimant No. 1 works eight hours a day, five days a week in the mines and is presently nearing retirement age.

The investigator was also informed that the Claimant's wife, who does not work, is also involved with the Miners Athletic Association.

The investigator further disclosed that the average of retirement in the mines is between 60 to 65 years of age.

SUNDAY, MARCH 6, 1977

The investigator again proceeded to the Claimants place of residence and set up re observations.

After approximately one hour, the investigator observing no sign of either Claimant or activities, discontinued observations.

The investigator, acting on a suitable pretext, approached the Claimants residence and was admitted into the residence by Claimant No. 1's wife who called Claimant No. 1 to the front door.

The investigator subsequently observed Claimant No. 1 who was not wearing any collar, brace or visible support and is described as (male, white, approximately 5' 11" in height, weighing approximately 230 pounds, approximately 59 years of age with grey hair) wearing blue slacks and a green plaid shirt.

During the pretext conversation, the investigator observed Claimant No. 1 to walk in an apparent normal manner and while talking to turn his head and neck from left to right and in an upward and downward motion and to motion with both his arms and hands.

During the pretext conversation, the investigator also observed Claimant No. 2 who later entered the front room of the residence.

The investigator observed Claimant No. 2 was not wearing any collar, brace or visible support. The investigator observed at this time that Claimant No. 2 while entering the room was doing so with the aid of crutches and placed all her weight on her right leg while lifting her left leg off the floor and having it bent at the knee. The left leg at this time was not in a cast.

Claimant No. 2 is described as (female, white, approximately 5' 2" in height, weighing approximately 120 pounds, approximately 16 years of age with brown hair) wearing glasses, blue jeans and a white pullover sweater.

During the pretext conversation, the investigator observed Claimant No. 2 to seat herself on the couch and at this time was attending to her homework while seated on the couch.

Claimant No. 2 appeared very cheerful and able to move around very well on the crutches and while seated and walking, was observed to turn her head and neck from left to right and in an upward and downward motion and to use both her arms and hands on the crutches while walking. Her only restriction appeared to be that of her left leg which was held off the ground while walking and placing her weight on her right leg.

During the pretext conversation, Claimant No. 1 stated that they were involved in a motor vehicle accident on September 26th, 1976 and at the time of the accident, Claimant No. 1 was driving his vehicle, a 1976 Plymouth Fury and his wife was sitting in the front seat and Claimant No. 2 was in the rear seat of the vehicle.

Claimant No. 1 stated that they were in the curb lane preparing to make a right hand turn when they were rear-ended. The vehicle sustained approximately \$700.00's damage to the rear-end and the left quarter panel and the impact caused the front seat to break.

Claimant No. 1 stated that he was taken to the hospital with a whiplash injury, left shoulder and a broken right arm. He further stated that he was in the hospital for two weeks and after his release took therapy until Christmas and that during this time he was off work for four months.

Claimant No. 1 went on to state that he is presently employed as a miner for INCO and has been working in the mines since 1936.

Claimant No. 1 went on to state that when he went back to work in the first part of the New Year, his doctor told him that it was too early to return to work but the Claimant felt he was able to return.

The investigator was also informed that the Claimant's wife, who was also in the vehicle, received a minor whiplash and injury to her right shoulder.

The investigator was informed that the shoulder injuries were believed to be caused by the wearing of the shoulder harness in the vehicle.

The investigator was informed that Claimant No. 2 who was a passenger sitting in the rear seat of the vehicle and at that time had her left leg in a cast because she had broken it earlier and that up to two weeks following the accident, Claimant No. 2 complained of a pain in her left hip and her doctor in Sudbury was not able to determine the cause of the pain.

Claimant No. 2 was subsequently taken to the Sick Children's Hospital and the cast on her leg was removed and they found that the previous break was broken again and did not heal properly because of the bones which had moved.

Claimant No. 2 subsequently had to have an operation on the leg and had it reset.

The investigator was further informed that Claimant No. 2 attended the Sick Children's Hospital last week and the cast was removed and the doctors told her she could start to put pressure on her leg and that it would take time for her to walk again.

The investigator was further informed that Claimant No. 2 is still attending school.

The investigator, unable to disclose any further information at this time, subsequently discontinued the pretext conversation and departed from the residence.

The investigator again set up re observations.

During the investigator's observations, Claimant No. 1 was observed motioning with both his arms and his hands, turning his head, shoulders and body from left to right, bending his head in a downward and upward position and walking about the residence in an apparent normal manner.

During the investigator's observations, Claimant No. 1 showed no signs of pain, physical discomfort or restrictions.

During the conversation, Claimant No. 1 showed no signs of mental strain or disorder.

During the investigator's observations, Claimant No. 2 was observed using both her arms and her hands, turning her head, shoulders and body from left to right, bending her head in a downward and upward position and walking about the residence with the aid of crutches and placing all her weight on her right leg while having her left leg in the air bent at the knee.

During the investigator's observations, Claimant No. 2 showed no signs of pain, physical discomfort or restrictions with the exception of having to walk with the aid of crutches while not placing weight on her left leg.

After approximately one hour, the investigator, observing no further sign of either Claimant or any activities, discontinued to complete reports.

MONDAY, MARCH 7, 1977 to MONDAY, MARCH 14,
1977

During this time, the investigator made numerous discreet inquiries in relation to the Claimants medical background and contacted the Sudbury Memorial Hospital and was informed that Claimant No. 1 was admitted to this Hospital on September 26th, 1976 and was discharged on October 9th, 1976.

Claimant No. 1's diagnosis was a motor vehicle accident causing strain to neck, whiplash and pulmonary insufficiency.

Other admission shown for Claimant No. 1 in the Sudbury Memorial Hospital are on July 30th, 1976 for bronchial C.A. and from January 11th, 1976 to January 24th, 1976 for prostatic hypertropy.

The investigator made further inquiries to learn of a consultation note written by Dr. S for the September 26th, 1976 admission which reads as follows:

This patient was admitted to the Sudbury Memorial Hospital on September 26th, 1976 having suffered a neck injury. He was sitting behind the wheel of his car which was parked at the time. It was struck from behind by another car. The front seat broke and the patient's hat was thrown into the back seat. He suffered what appeared to be a flexion extension injury of the neck. He said that it all happened so quickly that he cannot remember how his neck was forced. He developed pain in the lower cervical region to the right of the mid line and states that his right arm has been numb. However, he does not have any pain in the arm below his shoulder.

Examination: The patient has a reduction of neck movements due to discomfort. He points to the right

lower cervical region as the area involved.

This would be at the level of C6-C7. In the right arm there is some weakness of the bicep muscles but this may be due to the pain associated with this movement. No definite reflex changes are detectable.

The reflex on both extremities are equal. They are sluggish however. Regarding sensory findings, there was no definite sensory alterations at the present time. The X-rays have been reviewed. There is extensive cervical spondylosis at the C4-C5 and C6-C7. This would make these levels subject to trauma more so than the others. This patient was then fixed by cervical traction and we have ordered it. At the moment there does not appear to be any indication of a melographic. But this test will have to be carried out if nerve root compression consists.

Prognosis: Appear favourable for a reasonable good recovery. Although he may be left with some cervical symptoms secondary to spondylosis.

The investigator further disclosed that Claimant No. 1 was treated by Dr. K who treated him for the pulmonary insufficiency.

Claimant No. 1 has not been seen in the Sudbury General Hospital since his last admission on September 26th, 1976.

The investigator, unable to disclose any further medical information in relation to Claimant No. 1 subsequently contacted the Sick Children's Hospital in Toronto in regards to Claimant No. 2 and was informed that the Medical Records Department shows

Claimant No. 2 having been admitted on the following occasions:

June 27th, 1970 to July 11th, 1970 - for osteogenesis imperfecta. Bowed right tibia.

Segmentation osteotomy right tibia and intramedullary nailing.

Claimant No. 2 was again admitted on May 16th, 1972 through to May 29th 1972 for osteogenesis imperfecta and constipation. Replacement of the intramedullary nail osteotomy.

The Claimant was again admitted on June 28th, 1972 through to July 5th, 1972 for removal of cast and osteogenesis imperfecta.

The Claimant was again admitted on July 20th, 1976 through to July 28th, 1976. The file reads: osteogenesis imperfecta - operation, drill osteoclasis of left tibia and removal of intramedullary nail.

Claimant No. 2 was again admitted on October 27th, 1976 through to November 1st, 1976. The file reads: osteogenesis imperfecta with severe anterior bowing of left tibia - operation, osteoclasis of left tibia.

The investigator disclosed that the Claimant was first admitted to this hospital on October 16th, 1968 through to November 2nd, 1968. The file reads: osteogenesis imperfecta, perianal dermatitis and functional constipation.

The file also shows that the Claimant was seen in the clinic on January 14th, 1977 for a follow-up on the osteogenesis imperfecta and X-rays were taken.

Claimant No. 2 was treated by a Doctor Sa and a Doctor B.

The investigator disclosed in a final note in regards to Claimant No. 2 written on October 9th, 1976 the following:

is an old patient who was seen here and has been diagnosed as a osteogenesis imperfecta at the age of four. She has bilateral tibial operation in Sudbury. Following that she has been seen at Sick Children's Hospital wherein 1968 she has been treated for chronic constipation. In 1970 she had left tibialis anterior bowing and a sofield procedure was carried out. In 1972, replacement of intramedulary rod was carried out. In 1976, she had valgus deformities of the feet with pain in her ankle joints and removal of pin and drill osteotomy was carried out. She was put in a cast at the knee at 90 degrees.

Following this, the patient was involved in a car accident and three weeks ago injured her leg again. The cast was taken off on October 8th, 1976 and she was asked to mobilize the knee and ankle joints. She had been doing this and one of her osteotomys had not united. She still has severe anterior bowing of the left leg and again she was brought in for osteoclasia.

Physical Examination: was normal except for the multiple deformities of previous fractures and severe anterior bowing of the left tibia. She was taken to the operating room on October 20th, 1976 where under general anaesthetic, she had osteoclasia of tibia carried out and application of long leg cast. She did very well after this and was discharged home to be followed in our clinic on January 7th, 1977.

This report had been dictated by the resident of the Sick Children's Hospital.

The investigator, unable to disclose any further information in regards to Claimant No. 2 from the Sick Children's Hospital, subsequently contacted the Sudbury Memorial Hospital in regards to Claimant No. 2 and was informed that Claimant No. 2 was seen on September 26th, 1976 in the emergency department by a Doctor M and the report is as follows:

Motor vehicle accident - occipital contusion, osteogenesis imperfecta, no fractures. The doctor suggested a cold compress and sent her home on bed rest. Medication given was Atasol?

The investigator made further inquiries and was informed that there is no record of Claimant No. 2 having been admitted to the Sudbury Memorial Hospital.

The investigator, unable to disclose any further information in regards to either Claimants medical background, discontinued to complete reports.

WEDNESDAY, MARCH 16, 1977

The investigator subsequently contacted a confidential source in regards to obtaining employment background relating to Claimant No. 1 at his place of employment.

The confidential source advised the investigator that upon receiving this information, it would be immediately forwarded to our office. Upon our receipt of this information, the writer will immediately forward it to your attention in order to complete this investigation.

Report 4164

On May 16, 1976, a Co-operators' insured was involved in a motor vehicle collision which caused damage and injury to a claimant. On September 28, 1976, The Co-operators in Toronto,

instructed Centurion Investigation Ltd. to carry out an investigation of the claimant and to do a "Medical". By letter dated November 15, 1976, Thomas McGarry reported as follows:

TUESDAY, SEPTEMBER 28, 1976

The Investigator received case instructions from our office in regards to this investigation.

WEDNESDAY, SEPTEMBER 29, 1976 to FRIDAY, NOVEMBER 12, 1976

During this time the Investigator made numerous discreet inquiries in relation to the Claimant's employment and medical background.

The Investigator made discreet inquiries at the Personnel Department of [redacted], located at [address], Ontario, and was advised that Claimant, following his motor vehicle accident, May 16, 1976, had been absent from work from Monday, May 17, 1976, through to Friday, June 4, 1976, a total of three weeks.

The Investigator was further advised that, according to the records, the Claimant has not been absent since that time.

The Investigator was not able to disclose the Claimant's present salary or company benefits and was informed that no further information could be obtained without being requested in writing.

The Investigator then made numerous discreet inquiries in relation to the Claimant's medical background and contacted the Scarborough Centenary Hospital and was informed that the following X-rays are the only ones within the Claimant's file at this hospital.

The X-rays were requested by Dr. W.

May 16, 1976: A lumbar spine X-ray report reads as follows:

There are no previous films available for comparison. This patient has a compression fracture involving the superior plate of the vertebral body of L4. I am not certain if this is recent or old. If clinically indicated, I suggest that previous films be obtained for comparison. If not available, then probably a tomogram would be in order to determine if this fracture is recent or not. The rest of the vertebral bodies are otherwise normal.

May 27, 1976: Tomograms of the lumbar spine - reports read as follows:

A comparison was carried out with the plain films of May 16, 1976. The compression fracture of the superior plate of L4 vertebral body is demonstrated to better advantage. There is moderate irregularity of the superior plate, but no significant loss of volume of the vertebral body is noted. A fragment measuring approximately 1 cm in the widest dimension from the superior anterior margin is slightly tilted anteriorly. This is not completely separated in any of the tomograms, but I gained the impression that this is most likely recent.

The Investigator then contacted the Medical Records Department and was informed that the Claimant has been seen on two occasions at Scarborough Centenary Hospital.

He was first referred by Dr. W as an outpatient for physiotherapy.

He had 8 physiotherapy treatments from April 13, 1976 to April 29, 1976.

The diagnosis at that time was degenerative disc disease of the lumbar spine.

The Claimant was admitted from May 16, 1976 until May 22, 1976 following a motor vehicle accident in which he fractured his 4th lumbar vertebra.

He was treated with bed rest with two pillows under his knees.

There were no surgical procedures and the Claimant was under Dr. W's care.

The Investigator, unable to disclose any further information from the Scarborough Centenary Hospital, contacted the office of Dr. W, orthopedic surgeon, located at [address], Scarborough, Ontario.

The Investigator was advised that, according to the Claimants' file, he was first seen by Dr. W on May 7, 1976 for symptoms of lumbar disc disease.

The Claimant received hospital care commencing May 16, 1976.

He was seen in Dr. W's office again on May 31, 1976 and was last seen by Dr. W on August 6, 1976.

The Claimant had been referred to Dr. W by a Dr. D, a general practitioner.

The Investigator made further inquiries and was informed that no further information could be obtained from Dr. W's office without written authorization.

The Investigator subsequently contacted the office of Dr. D, a general practitioner, located at [address], Ajax, Ontario.

The Investigator was informed that Dr. D has been the Claimant's family doctor for quite some time, off and on.

Dr. D had seen the Claimant as an adolescent, then the Claimant had married and moved away and Dr. D did not see him for a while.

The Claimant then came back with complaints of low back pain.

The Investigator was informed that the Claimant's only major complaints have been low back pain and fairly severe acne.

He has been treated for nothing else of any major consequence and his family history is essentially negative.

The Investigator was further advised that the Claimant's back problems date back approximately 1 1/2 years and there is no history of an initial injury.

X-rays have been taken on several occasions at both Ajax-Pickering Hospital and the Medical Arts Building X-ray Clinic.

The Investigator was advised that, according to the Claimant's wife, he had lost a fair bit of weight and was quite disabled with his back for a period of several months; however, the Claimant would belittle these things and would not claim to any great disability at all.

The Claimant was in to see Dr. D for a thorough examination but the doctor did not find anything.

The x-rays of his back were apparently O.K.

Dr. D was concerned with the Claimant's weight loss and referred him to an internist.

Extensive tests were done but all were negative.

The Claimant was also referred to Dr. W with a diagnosis of low back strain.

Dr. D commented that Dr. W had never been terribly impressed with the Claimant's back pain.

The Investigator was informed that, at one point, Dr. D admitted the Claimant to Ajax-Pickering Hospital for a few days of bed rest and physiotherapy.

The Claimant came into the hospital stooped over and could not move very well; however, within a few days he was fine again, the back pain had settled down and his mobility had improved.

At that point, Dr. W suggested that the Claimant be discharged home on an exercise and physiotherapy program.

Dr. D had tried to find some psychological basis behind the Claimant's complaints but did not get very far.

The Investigator was further informed that the Claimant's admission to hospital was approximately one week prior to his involvement in a motor vehicle accident and Dr. D had not seen him since that time.

The Claimant sustained a compression fracture of L4 in the car accident and went directly to Centenary Hospital where Dr. W cared for him.

He was treated with a period of bed rest in hospital and back supports after discharge.

The Claimant was followed by Dr. W and apparently made an uneventful recovery.

The Investigator, unable to disclose any further information from the office of Dr. D, then contacted the Ajax-Pickering Hospital X-ray Department and was informed that the Claimant has had no x-rays done at this hospital since 1971.

At that time x-rays were taken of his chest, foot and ankle.

He has had no x-rays of his spine at all.

The Investigator then contacted the Medical Records Department of the Ajax-Pickering Hospital and was informed that the Claimant was admitted under Dr. D's care from May 7, 1976 until May 11, 1976 with a final diagnosis of low back pain due to lumbro-sacral degenerative disc disease.

A bone scan was carried out while the Claimant was hospitalized and this was normal.

Dr. D's discharge summary states:

A 26 year old white male admitted with low back pain and weakness. There is some question of an emotional overlay to his complaints. Dr. W saw the patient in consultation and was not impressed that he had serious nerve root irritation. He was treated with physiotherapy and bed rest, has been fitted for a lumbro-sacral support and was discharged with this to continue with exercise program. He will be seen in the office for follow-up following discharge and continued on conservative means. Myelogram was considered but postponed for the time being.

The Investigator then contacted the Medical Arts Building X-ray Clinic and was informed the following x-rays were taken of the Claimant on February 9, 1976:

Thoracic Spine. The report reads as follows:

Projections of thoracic spine show a typoscoliosis and some marginal bone spurring, but no other significant pathology is demonstrated.

Lumbar Spine. The report reads as follows:

The views of the lumbo-sacral spine show a slightly augmented lumbar

lordosis, but no other significant abnormality is demonstrated.

The only other x-ray ever taken of the Claimant at this clinic was a chest film.

The Investigator, unable to disclose any further information in relation to the Claimant's medical background, subsequently discontinued to complete reports.

Report 4458

On March 4, 1976, a Co-operators' insured was involved in a motor vehicle collision which caused injury to a claimant. On January 24, 1977, Keith Routledge, an employee of The Co-operators in Owen Sound, informed Centurion Investigation Ltd. that the claimant had "severe brain damage" and might "be a vegetable for the rest of his life". Mr. Routledge retained Centurion to do a "Medical". By letter dated March 11, 1977, from J.T. McGarry addressed to Mr. Routledge, Centurion Investigation Ltd. reported as follows:

WEDNESDAY, JANUARY 26, 1977

The investigator received case instructions from our office in regards to this investigation.

The investigator commenced enquiries at the York County Hospital, New Market, Ontario Medical Records Department at which time the investigator was advised that the Claimant is still in the hospital, therefore, his medical chart is active and not in their records.

THURSDAY, JANUARY 27, 1977 to FRIDAY,
FEBRUARY 11, 1977

During this time the investigator continued discreet enquiries in regards the Claimant's medical background and subsequently disclosed from Sunnybrook Hospital, Medical Records Department, the following information relating to the Claimant:

The patient was admitted on March 5, 1976 for treatment of a brain stem injury. His diagnosis also included

- left fracture of the clavicle;
right wrist fracture and pelvic
fracture.

The following is the discharge summary
written by Dr. R, dated May 27, 1976:

Treatment and course in hospital.
He had a chest tube for a hemo-
pneumothorax: kept in intensive
care. He developed pneumonia. He
was treated with Decadion. He had
complication of GI bleeding. Neuro-
logical state hadn't changed much.
He also had a tracheostomy on March
9th and this was removed in May.
Fractures healed and he had no chest
problem on the day of discharge.

Summary:

His prognosis is fair. He passed
his acute state and has been been
transferred to chronic care.

TUESDAY, FEBRUARY 15, 1977 to FRIDAY, MARCH
4, 1977

During this time, the investigator continued
discreet enquiries in regards to the
Claimant's medical background and subse-
quently disclosed from the York County
Hospital, Newmarket, Ontario, Medical
Records Department, the following informa-
tion, relating to the Claimant: Admitted to
hospital May 27, 1976 and discharged
February 8, 1977. The admitting diagnosis
was brain stem injury and pneumothorax.
Several x-rays were taken as follows:

May 31, 1976 - portable chest x-ray: There
are old fractures of the ninth rib on the
right and the left clavicle.

July 8, 1976 - portable chest x-ray and
abdomen: Normal.

July 12, 1976 - portable chest x-ray and
abdomen x-ray: Fractured ribs are again
noted.

July 16, 1976 - portable chest x-ray: The lung fields are clear and the heart is normal.

October 4, 1976 - portable x-ray: An old fracture of the left horizontal ramus of the mandible has been shown. There seems to be a slight displacement of the lateral fragment, lying a little lower in position of the central point.

October 12, 1976 - pelvic x-ray: A little deformity is evident in the left inferior pubic ramus. It is uncertain whether this is longstanding or indicates recent impact fracturing. Additional views of this can be done to determine which.

October 12, 1976 - left knee x-ray: The bones are osteoporotic. There is a healing fracture of the neck of the fibula. There is a slight displacement of the left ankle. There is considerable osteoporosis. The lateral view is not a standard projection, but there may be a comminuted fracture of the oscalsis.

November 6, 1976 - neck for soft tissue: There is minimal concentric narrowing of the trachea to 4 centimeters distal to the vocal cords. Diameter, at this point, is 1.7 centimeters. The diameter of the trachea distal to this is approximately 2.2 centimeters.

There is no summary on the chart.

The investigator continued enquiries, but was unable to disclose any further information in relation to the Claimant to assist this investigation.

On June 23, 1977, Mr. Routledge requested Centurion Investigation Ltd. to do a further "Medical" and to "do an update concerning the termination of confinement at Sunnybrook Hospital and Newmarket Hospital so as to determine the patient's present condition, current treatment, and diagnosis." By letter dated July 12, 1977, Centurion Investigation Ltd. made the following report to Mr. Routledge:

FRIDAY, JUNE 24, 1977

The investigator received case instructions from our office in regards to this investigation.

MONDAY, JUNE 27, 1977 to FRIDAY, JULY 8, 1977

During this time, the investigator, through confidential sources and discreet enquiries, subsequently disclosed the following information relating to the Claimant's medical background.

The investigator disclosed from the York County Hospital in Newmarket, Ontario, the following information:

"The patient was admitted to the Hospital on May 27, 1976 with an admitting diagnosis of MVA with mid-brain damage; multiple bony and soft tissue injuries.

The patient's O.H.I.P. number is

The following note was written by the patient's family doctor, Dr. H:

'This 23 year old man recently immigrated from Ireland to this country. On the evening of the 4/3/76 he was involved in a MVA on Highway 400. From the scene of the accident he was taken by ambulance to York Central. In the Emergency Dept. there the patient was reported being deeply unconscious, without spontaneous movements and his respirations were irregular.

After this initial evaluation and treatment he was transferred from their Emergency Dept. to Sunnybrook Hospital Emergency Dept.

On initial examination there the patient was described as being deeply unconscious, showing signs of

bilateral decerberate posturing and irregular, rapid respirations. Major problem was his major head injury but there was also multiple areas of contusions and multiple fractures. Fractures included fracture of the left clavicle; right 9th and 10th rib; left inferior pubic ramus, left 5th metacarpal; left fibular head. There were also comminuted fractures in the left calcaneus and the base of the proximal shaft of the 5th metacarpal. Soft tissue injuries included a left knee effusion, a lateral ligament disruption of the left ankle. It was also noted that there was no evidence of chest or abdominal injury. It was reported at that time that the only focal neurological findings were deviation of the eyes, the right eye being hypertrophic. Pupils were small and reacted briskly to light.

After the first few hours at Sunnybrook, the patient improved slightly and retained most brain stem reflexes and showed improvement of motor activity on the right side. The initial irregular respirations began to show improvement to the pattern of continuous hyperventilation. It is commented here that this is compatible with mid-brain injury.

Dr. R, the Neurosurgeon, who looked after at Sunnybrook, felt, at that time, that the patient had sustained a contusion sustained a contusion of the lower mid-brain and right pons with probably multiple areas of cerebral contusions in these hemispheres.

The day after admission to Sunnybrook, a small pneumothorax on the left side showed and became

evident on x-rays and required a chest tube to be inserted. It was also reported that there had been some gastrointestinal bleeding and so his Decadron was discontinued and he showed some deterioration from this. At that time he also became somewhat hypoxic - consolidation had developed in the left lung either due to pneumonitis or pulmonary contusion. Cerebral angiography was carried out at that time because of deterioration but no evidence of a mass lesion was found.

On the 9/3/76 a tracheostomy was carried out to improve tracheal-bronchial toilet. On the 16/3/76 angiography was repeated because of his continued failure to improve and again was normal.

showed little improvement from then on and suffered recurrent pneumonias which were always treated successfully and at the end of March he developed a hemopneumothorax of the right side which required drainage.

Before discharge from Sunnybrook to York County Hospital for CCU he was described as a patient showing the picture of akinetic mutism with marked increase in tonus in all extremities.

His tracheostomy tube had been removed and he was tolerating naso-gastric tube feedings.

Dr. R felt at that time of transfer that it was extremely unlikely that the patient would ever recover useful neurological function. However, he felt his condition at that time was stable and that all that was required was continuing care with physiotherapy.

The patient was then admitted to York County Continuing Care on the 27th of May. At that time he had D-tube feedings with Sulphagen and he had a catheter in situ and his medication included: Dilantin, Amphojel, Digoxin, Sodium Chloride tablets, Dulcolax suppositories, Beminal C. Fortis, Thiamine, Ferensol, Milk of Magnesia and Tylenol.

Examination of the patient at the time of admission showed that he would open his eyes on entrance to the room and would follow you around. However, he would not answer any questions and physical movements such as tapping or blinking in answer to a question were not reliable. He was not anemic, cyanosed, or jaundiced and no lymphadenopathy was detected. His tracheostomy site was covered with a bandage and at that time he had continual juttering of his jaw.

Examination of the chest showed that percussion note was resonant and breath sounds were vesicular with conducted noises from the trachea. In the right anterior auxillary line, the drainage site now closed. The abdomen was soft and there was no obvious tenderness or guarding and the bowel sounds were normal. External genitalia was normal. CVS stable - pulse 80 and regular, blood pressure normal at 110 systolic and 80 diastolic.

Examination of the extremities showed pressure areas on both ankles and also one with scab on his left wrist. Buttocks were only reddened.

Examination of CNS showed equal pupils, round reactive to light and

there was nystagmus to the right. Patient's inability to follow instructions made it difficult to elicit cranial nerves through, though he would move his eyes in the direction requested. Power again could not be detected but the tone at this time seemed normal in all movements allowed in the four limbs, however, there are contractions in both elbows which limited the extension by about 30 degrees. Left knee also showed limited movement possibly due to _____. He responded to painful stimuli in most areas and the reflexes showed equal biceps, reflexes on the left and right, and the knee reflexes normal on the left but difficult to elicit on the right. Both plantar responses were extensor or equivocal but certainly not a plantar.

On the 31st of May Dr. P saw this patient. At the time he was asleep and he felt that he had increased tone of all extremities with an up-going left plantar and equivocal right. Dr. P found him to react to painful stimuli and found that he occasionally obeyed a simple command - example, move the hand. His respirations were regular at that time and he noted the tracheostomy scar and deflection deformities at the elbows and knees. At that time vital signs were stable and management was to continue medication as prescribed from Sunnybrook with periodical reassessment, physiotherapy and medical symptomatic care.

Dr. M, Neurologist from Wellesley, also saw this patient and he followed him with his eyes appropriately but he could elicit no spontaneous movement to command. He found the fundi were normal with

nystagmus to the right with an inferior gaze to the right. Pupils he found mid-size and equal to reaction and light and he responded to pain bilaterally. He also found he had what was described as a "doll head". He found that the facial musculature was hypotonic and with a positive second reflex. Reflexes were hypoactive and he had bilateral upgoing plantar responses. He also described him as having atonic respirations with early flexion contractions of the left knee and hypertonic left arm with cerebrate posturing of the arm. His opinion was that he had a "locked-in" syndrome with a mutism and _____ deficit with cerebrate posturing. He agreed with present management.

Physio was started soon after admission. The initial comments from physiotherapy show that he was a thin man rather than having gross muscle atrophy. The therapist felt that both left and right sides increased muscle tone of left more so than the right and upper extremities were more than the lower. In fact he felt the right leg movements were reasonably good except at the ankle. The patient was described as reacting toward stretching with no pain nor spasticity. Treatment was at this stage begun with passive gently stretching of all joints and rolling from side to side to avoid chest problems.

The nurses, on admission, noted that he had spasms in the arms and legs when being bathed and that there were numerous reddened areas at the pressure points. Physiotherapy continued with active leg movements and arm along with stretching of the arms. Physio to the chest included vibration and expirations.

On May 30th he was placed on a geriatric chair and wheeled into the TV room. The nurses asked whether he would tap twice if he enjoyed the TV and he tapped four times. He also squeezed the hand when asked to and tried to dry his face with the towel. The nurse also noted again that he followed her with his eyes.

On June 1st his temperature rose to 38.4 and he vomited more amounts of brown fluid. However, his pulse was regular and his blood pressure normal tensus. Examination of the chest and abdomen showed no abnormal findings. A chest x-ray, urinalysis, blood culture was carried out and a three-way Foley with irrigation catheter inserted. Chlorpromazine was used for vomiting. On the same day, , Social Worker, was to see the patient and start social work with the family contact.

June 2nd, he was apyrexial with no vomiting and physiotherapist also found him improved.

By June 9th he seemed to be more responsive in so much that he would squeeze the hand on command, but otherwise little change. The social worker had been in contact with Mrs.

and had had a free discussion with her and did note that there was a lot of emotional stress at work. Physiotherapy was continuing with clapping as before and at this stage the patient was assisting the therapist with rolling over and deep breathing exercises on command.

By June 10th there had been some blood noted rectally. However, examination of the abdomen and rectal examination had failed to show any abnormal findings and it

was felt this was probably due to his constipated stool causing trauma at defecation. When passing constipated stool, the patient would tend to pick these up and throw them over the bed sides.

By June 13th again he was a little more alert by raising his head when you went into the room and following with his eyes, again squeezing the hands on command. The therapist also noted that he was more lively and began to act out against his environment. Also at this stage he began to attempt taking his feedings by mouth and then, asked whether he wanted a drink, he made a grunt in a affirmative way.

By June 14th he would tend to lift his hand and attempt to wave when the visitor would say goodbye on leaving the room.

On June 17th the patient shook his head in a yes fashion to a question. Again therapy was continued and the therapist felt there was gradual improvement in his condition.

On June 20th the patient had reversed and fell back in the bed so that his head was at the foot and his feet at the head end. He was very alert, followed the staff well and turned his head to each person as they spoke in turn. At this point, the Registered Nurse felt that her explanation to him of why he was in the hospital was comprehended by the patient. It was also at this stage felt that the therapy starting to use the tilt table would try and give him some positional feeling.

On June 22nd, was handed a face cloth and he washed his face

and dried it with one hand with a towel.

On June 25th the patient began to eat puree foods willingly and without any choking.

On June 30th the patient began to have his catheter clamped to try and give more tone to the bladder. He was offered bedpans to try to help his incontinence and the Amphojel was stopped. His speech therapy assessment was requested at this stage along with occupational therapy assessment in the future. It was thought an orthopedic and visual assessment would be suitable.

Occupational therapy assessment on June 30th showed that he knew the colours, red, black, brown, green, blue and he was able to cross at the mid-line right hand to left eye, left arm with assistance of right to the face, right hand to left shoulder. Also felt that nodding of the head for positive and negative for negative were appropriate.

On July 2nd he began standing on the tilt table, practicing balancing and was standing free with quite a lot of support. He seemed pleased with his progress. By this stage he was taking solids and fluids well orally. The sodium Chloride liquid was also discontinued at this point.

July 3rd, the patient fed himself alone with supervision and did well. He took a glassful of fluid in his right hand, drank without help, spilled only approximately one mouthful. He indicated that he was still thirsty and drank another glass by himself.

On July 5th he started to vomit and it was found that he had an acute gastric dilatation which required an IV and Maxeran to settle.

By July 9th his condition had deteriorated quite considerably with pyrexia 38.7, pulse 169 and blood pressure 100/70. However, although his condition was very poor at this stage, he recovered well over the subsequent two weeks. It was however a rather stormy course with difficulty restarting subclavial intravenous lines and electrolyte disturbances.

By the beginning of August he was back to taking full fluids orally and had reattained his physical and mental condition he had improved to before this set-back.

By August 13th the patient was rearranging letters on a board to form words. Also he was picking out letters from a group to form words.

By the end of August there had been good improvement with regards to tone in the arms and legs, strength, and in the contractures. Catheter clamping had been a problem so much that he was getting spasms in this and so Probanthine was tried to see whether this would help the spasms which it did.

In mid-September he had a pseudo-monas urinary tract infection which required treating. Occupational therapy had been continued with his wife in attendance and it was noted that he worked only a short period and tired quickly or it was wondered whether this could be due to stubbornness. He was attempting simple mathematical questions.

By the end of September the patient was starting in parallel bars to assistance. It was noted that he was continuing to recover his right eye from light.

On October 2nd, Dr. D, our ophthalmologist, checked his eyes and could find no acute problem with the limiting examination that he could perform on .

On October 6th he was seen by Dr. O, Dental surgeon, who assessed 's dentition with _____ x-ray and it was found that some dental work was indicated with hopes that this would be able to be done at Sunnybrook Clinic when he went to see Dr. R on the 18th of October.

By October 7th it was noted that he was beginning to attempt words such as pee, goodbye, etc., and although poorly understood, were audible and recognizable.

On October 11th had a convulsion and it was decided to continue the Dilantin which had been stopped earlier in the year.

On October 18th went to see Dr. R at Sunnybrook Medical Centre. Some comments from his letter I will include here: He noted that had made a great deal of improvement since leaving Sunnybrook at the end of May in that his left-sided hemiplegia was still severe but that there were definite signs of improvement and he had begun to have individual finger movement in the left hand at that time. He has also noted that he had a moderately severe cortical hemi-sensory loss in the left side still but it was difficult to pursue at that time

because of his residual difficulty with speech.

His eye examination had improved but was still detectable and the right eye remained hypertrophic. On the right side he felt he had good motor activity although there was still a reasonable amount of limb ataxia. He noted that there was still some residual increase in tonus on both sides, more markedly on the left and both plantar responses had remained extensor. His speech he noted was still dysarthritic but the content in so far as it could be judged was from his replies, fairly reasonable. He felt that continuing the physiotherapy and speech therapy we can still expect some further improvement and he may even be capable of living independently from an institution.

Dr. R also noted that the tracheostomy site was still open and this may require a revision and that the left ankle could require some operational revision at a later date and that his bladder would continue to be a problem, but removal of the catheter would be tried.

On October 20th the catheter was removed and condom drainage was instituted which worked well. At the end of October the Probanthine was stopped, the Maxeran decreased to twice daily dosage, and Dilantin decreased to a daily dosage. He was ringing for a urinal and his periods of incontinence were becoming less. His alertness and speaking were improving all the time and on the weekend of October 30th he went home on a pass.

Early in October the Maxeran was stopped and Dr. H asked to see the

patient with regard to reviewing the tracheostomy stoma and at that time he found a small fistula opening at the previous tracheostomy site but he felt that it didn't contribute to the main problem of speech and breathing. He felt that it was most likely he either had a significant left vocal cord paresis or either a granuloma or a stenosis of the upper larynx related to this 5 day intubation preceding the tracheostomy. However, on November 11th, Dr. Hall did a direct bronchoscopy and laryngoscopy with revision of the tracheostomy fistula and saw that there was bilateral cord paresis.

By February 8, 1977 when he made a return trip to Dr. R at Sunnybrook, he was walking with a frame, speaking comprehensively and beginning to become selfsufficient in many aspects of his everyday life.

On February 18/77, the patient was discharged home."

The investigator disclosed from the office of Dr. H, a General Practitioner, office located at [address], Newmarket, Ontario, that, to the best of the doctor's knowledge, the Claimant had returned to Ireland during March or April of 1977 to reside there on a permanent basis. The doctor has no up-to-date knowledge of the Claimant's present condition.

When the doctor last examined the Claimant, he was still walking with the aid of a frame and having a few difficulties with his speech, but the doctor noted that the Claimant was progressing fairly well.

The investigator was unable to disclose any information from the Sunnybrook Medical Centre, without proper written authority.

The investigator made further enquiries, but was unable to disclose any further information to assist this investigation.

From approximately April, 1976, Dunlop Goodchild was claims manager of The Co-operators in Ontario. He was associated with The Co-operators for more than 25 years. His experience was mostly in the claims area. He testified that The Co-operators began doing business with Centurion Investigation Ltd. about the year 1974. At this time, Centurion Investigation Ltd. emphasized surveillance. Gradually however, it began to provide medical information. The Co-operators accepted this medical information and, eventually, began to expect it. In November, 1977, Mr. Goodchild, after consultation with a solicitor finally recognized the danger and impropriety inherent in the receipt of Centurion Investigation Ltd.'s investigation reports containing medical information obtained without patient authorization. As a result of this realization, in November, 1977, he instructed all claims personnel in Ontario, in writing, that no further investigators were to be retained until he could formulate strict and proper guidelines. This directive antedated the creation of my inquiry in December, 1977.

In February, 1978, Mr. Goodchild had all investigators hired by The Co-operators notified of the guidelines which he had established. The letter to Centurion Investigation Ltd. was in the following language:

THE CO-OPERATORS

Priory Square - Guelph, ONTARIO
N1H 6P8 - 824-4400

February 24, 1978

Centurion Investigations,
100 Sheppard Avenue West,
Toronto, Ontario.
M2N 1M7

RE: Investigations

Dear Sir:

For your information the following guidelines will be observed when conducting an investigation for any office of The Co-operators in Ontario:

1. When interviewing a claimant who is not represented by a solicitor a claims representative will correctly identify himself as a representative of The Co-operators.
2. When interviewing a claimant who is not represented by a solicitor, a representative of an investigation service or other person acting on our behalf will correctly identify himself and the fact that he is representing The Co-operators.
3. There will be no pretext interview or direct contact with any claimant represented by a solicitor unless the claimant has properly and of his own accord withdrawn his retainer or unless the claimant's solicitor has given his permission for such interview or contact.
4. Medical information will not be sought or obtained from any medical practitioner or hospital without the written consent of a party who is the subject of the enquiry.
5. A surveillance may be carried out but during the course of any such surveillance no affirmative action to entrap a claimant will be taken.
6. There will be no use of paid informers to obtain information on claimants other than the payment of rewards through proper law enforcement authorities.

Extraordinary circumstances such as suspected fraud may necessitate some deviation from these guidelines. However, any deviation must be authorized by the division claims manager.

Effective immediately, we may utilize the services of any investigation service to interview neighbours, employers,

acquaintances, etc. of claimants or to carry out surveillances of claimants.

Yours truly,

J.D. Goodchild,
Claims Manager
Ontario Division

JDG/jb

In April, 1978, Teunis Haalboom was chief executive officer of The Co-operators. He had been the chief executive officer from 1977, when a group of insurance companies came together under the name, The Co-operators. This group included the CIAG which had ordered the reports received from Centurion Investigation Ltd. He had been CIAG's chief executive officer. As the chief operating manager, he had general responsibility for the day to day operations and supervision of the group of companies carrying on business as The Co-operators. He had never personally become involved in the claims aspect of the business.

Both Mr. Goodchild and Mr. Haalboom, personally and on behalf of The Co-operators, and its employees acknowledged that:

1. Hospitals and their employees and physicians and their employees have an obligation to keep the contents of the health records of the patients confidential ("the principle of confidentiality") and this was and is a subsisting and recognized principle.
2. The Co-operators and its employees knew or ought to have known the principle of confidentiality subsisted and was a recognized principle and ought to have accepted that principle.
3. The Co-operators and its employees in the course of their duties instructed Centurion to carry out investigations when they knew or ought to have known that Centurion during the investigation would obtain confidential medical

information from hospitals or physicians without the consent of the patient.

4. Centurion Investigation reports containing confidential medical information from hospitals or physicians were received by Co-operators' employees in the course of their duties and utilized in the evaluation of claims or for the setting of reserves.
5. Centurion ought not to have been retained, as the obtaining of confidential medical information without the patient's consent violated the principle of confidentiality.
6. The Co-operators accepts as a matter of corporate policy that confidential medical information ought not to be sought or received by the company, its servants, employees, agents and investigators without the patients' prior consent.
7. The principle of confidentiality was accepted by The Co-operators, not just in Ontario, but across Canada as the basis upon which investigations would proceed in the future.

Mr. Goodchild informed me that, in the year 1977, The Co-operators dealt with 4,505 accidents which gave rise to 5,517 bodily injury claims. He estimated that, although no separate record had been kept, investigation reports were obtained in four per cent to six per cent of the bodily injury cases. During our inquiry we developed the practice of asking all individuals of corporations who agreed to co-operate to search their files and deliver all relevant material. Mr. Goodchild had the staff of The Co-operators search through files to obtain typical copies of investigation reports prepared by investigation agencies other than Centurion Investigation Ltd. and deliver to us those reports which, on a fair reading, led to the conclusion that health information had been obtained without the consent of the persons being investigated.

Douglas Goudie, Q.C., and Brian Wheatley, Q.C., were retained by The Co-operators and their employees to represent their interests before me. Mr. Goudie and Mr. Wheatley

immediately attended upon Commission counsel and, on behalf of their clients, offered The Co-operators' full co-operation. They were the first counsel to recognize that it was necessary for me to determine the facts before I could proceed to make any recommendations and that a hostile adversarial attitude toward the inquiry was unnecessary. There was an immediate recognition and admission that The Co-operators had acted improperly. They expressed a desire to aid in formulating solutions to the problems which were perceived as having led The Co-operators to accept this practice. This co-operation led to a substantial saving of time and effort.

I express my gratitude to Mr. Goudie and Mr. Wheatley and The Co-operators for their frankness, co-operation, and attempts to encourage other corporations and individuals to come forward and try to assist our work. They acted in the highest tradition of the legal profession.

A.I. MacFarlane & Associates Ltd.

A.I. MacFarlane & Associates Ltd. which I shall refer to as MacFarlane & Associates, is an Ontario company carrying on business as an independent adjusting firm. The majority shareholder is Allen Inglis MacFarlane. He is an adjuster who, for the last 10 years, has been engaged exclusively in the adjusting of property losses. During the period I am concerned with, MacFarlane & Associates employed six adjusters and adjusted approximately 200 cases annually involving bodily injury. An investigation firm was retained in approximately 10 per cent of the annual case load or 20 to 22 cases per year. No internal directives existed prior to May, 1978, which delineated the circumstances in which private investigators were to be retained and the directions to be given to them. Our investigation disclosed 21 files in which Centurion Investigation Ltd. had been instructed to carry out investigations by employees of MacFarlane & Associates.

Derek Ian Bonner is an intelligent and articulate individual who gave evidence for approximately one and a half days. At the time, he testified, May 11, 1978, he had had 12 years experience as an adjuster, the last six in the employ of MacFarlane & Associates. Before that he had been a police officer for 13 years. He was the first witness from the insurance and adjusting industry to give evidence. He acknowledged as generally accepted principles and, certainly, as principles which he accepted:

1. that as an adjuster, he would not deal directly with a claimant who he knew was represented by a solicitor;
2. that physicians and their employees and hospital employees had a duty not to release health information without their patients' consent;
3. that it was improper for an adjuster to encourage physicians, nurses or hospital employees to breach their duty or to retain an investigator to do so.

Mr. Bonner's evidence may fairly be summarized in point form.

1. He never instructed Centurion Investigation Ltd. to obtain medical information without the claimant's consent;
2. he did not know how Centurion Investigation Ltd. obtained health information;
3. he never asked how Centurion Investigation Ltd. obtained health information;
4. he never considered how health information might have been obtained by Centurion Investigation Ltd.;
5. he never knew or considered that there might have been an unauthorized review of medical records;
6. he never considered that the obtaining of health information without the patient authorization was improper.

Of the 21 files in which Centurion Investigation Ltd. prepared reports for MacFarlane & Associates, 19 of them had been assigned by Mr. Bonner to Centurion Investigation Ltd. In some cases, Mr. Bonner was instructed by his principals to retain Centurion Investigation Ltd., but in others he recommended to his principals that that company be retained. I shall briefly review some of these 19 files to explain why I cannot accept Mr. Bonner's evidence that related to his appreciation of the source of the health information.

As I have indicated, Mr. Bonner denied that he had expressly instructed Centurion Investigation Ltd. to obtain medical information. A fair reading of all of the Centurion investigation reports leads to no other conclusion than that Mr. Bonner did, in fact, instruct Centurion Investigation Ltd. to obtain medical information. For example, Centurion investigation file 4145 contains a notation of particularized instructions from Mr. Bonner to obtain a "Medical". This phrase was always interpreted by Centurion Investigation Ltd. to mean that medical information was to be obtained from hospitals, physicians or from some other source. Mr. Bonner stated that he believed that medical information meant that the claimant "was wearing a cervical collar, plaster cast or whatever" and was information that "might be seen on observation." I cannot accept this explanation because many of the reports received by him contained such statements as "Dr. _____'s discharge summary ...read as follows:" Upon reading that kind of statement, he must have understood that access to medical records had been obtained. Yet Mr. Bonner never complained that Centurion Investigation Ltd. had not carried out his instructions when it failed to do a surveillance.

On November 7, 1975, a motor vehicle insured by Commercial Union Assurance Company of Canada was involved in a collision which caused damage and injury to the claimant. A Commercial Union adjuster assigned the adjusting of this matter to Mr. Bonner. On January 24, 1977, Mr. Bonner instructed Centurion Investigation Ltd. by telephone to do a "Medical", to develop any background information, and to determine why the claimant had terminated her employment and whether she had been involved in any other accidents or problems. Centurion Investigation Ltd. delivered a confirmation setting out that it was to do a "medical and any background regarding employment and previous accidents." The report made to Mr. Bonner by Centurion Investigation Ltd. read as follows:

MONDAY, JANUARY 24, 1977

The investigator received case instructions from our office in regards to this investigation.

TUESDAY, JANUARY 25, 1977 to TUESDAY,
FEBRUARY 15, 1977

During this time, the investigator made numerous discreet inquiries in relation to the Claimant's medical background and contacted the office of Dr. P, a General Practitioner, and was informed that Dr. P first saw the Claimant approximately two to

three years ago. The Claimant has juvenile rheumatoid arthritis very severe.

The investigator was informed that the Claimant has rheumatoid arthritis in every joint in her body. She is on myochrysine 1cc every week. Her blood is checked every two weeks. She's on prednisone 5 mg. twice daily and codeine phosphate 60 mg. four times a day; naprosym 250 mg. twice a day.

She was involved in a motor vehicle accident in November of 1975. She was struck from behind. She had a whiplash to her neck. She suffered quite considerably with that as she was pregnant at the time because we had to stop all the treatments because of the fetus. She had a exacerbation of the arthritis and her neck was hurting her like hell and the pregnancy threat was very uncomfortable for her. The accident aggravated her arthritic condition.

Dr. P last saw the Claimant on January 14, 1977. She had no complaints at that time. She was just in for her weekly dose of myochrysine.

The investigator, unable to disclose any further information from the office of Dr. P, contacted the office of Dr. T, an Arthritic Specialist, and was informed that Dr. T has been treating the Claimant off and on for years; approximately five to ten years.

She has got very, very severe rheumatoid arthritis which goes right back to childhood - since age 2. She is in her 20's now and she seems to be getting around to see various people. She is on multiple drugs for her arthritis including imuran. She's had one total hip arthroplasty.

The doctor states that she has a long history of treatment and has general rheumatoid arthritis involving multiple joints. Dr. T stated that he has not seen the Claimant for approximately six months.

The investigator, unable to disclose any further information from the office of Dr. T, contacted the office of Dr. B, an Orthopedic Surgeon who stated that he has no file on the Claimant.

The investigator then contacted the medical records department of Sunnybrook Hospital and was informed that:-

The patient has had three admissions to our Hospital all for the same diagnosis, rheumatoid arthritis. The first admission she was discharged in December of 1973. The second admission was the end of 1974 and the last admission was in October of 1976. For all three admissions, she was under the care of Dr. T.

Dr. T's discharge summary dated October 27th, 1976 written on the patient's last admission reads as follows:-

This 25-year-old girl was admitted for reassessment. She first developed arthritis at the age of two. This affected her right knee and she had problems with both knees and both ankles until about the age of twelve. Biopsies were carried out and definitive diagnosis was not made and at one point she received full chemotherapy for TB. She was in and out of a wheelchair over this period of time. Still's disease was diagnosed eventually and her disease settled in her teens.

From about the age of 12 to 19, she was able to walk, play tennis and field hockey. Her only problem being occasionally mild discomfort and swelling of her knees.

At 19 her disease spread and involved her hips, elbows, wrists, MP joints, PIP joints and knees and ankles. Over the past five years,

these joints have become increasingly more involved with exacerbations from time to time.

Two years ago, she had a left hip prosthesis inserted. One year ago, she became pregnant and her gold and chloroquin were discontinued. She delivered a normal child three months ago and at that time, her gold and chloroquin therapy were recommended. By this time, her arthritis had flared up and her functional status on admission was that she could only walk half a block with discomfort and pain in the right ankle and she was having extreme difficulty using her right arm which was very weak. She experienced a lot of pain in her right wrist and in the MP joints and PIP joints of the right hand. She is experiencing morning stiffness until about 2:00 p.m.

On admission, she was taking Prednisone 5 mg. BID; Chloroquin 250 mg. OD; gold once weekly; Entrophen 1.2 grams QID; Codeine 60 mg. in the morning. There were no other relevant symptoms on admission.

Investigations: Urinalysis - negative. Hemoglobin 10 grams; Hematocrit 30.7 ESR-45; WBC 10,700; 70% polymorphs - hypochromic mycrocytic picture; 610,000 platelets.

BUN 16; serum creatine 0.6; serum electrolytes normal; serum proteins - total 7.5; serum albumin - 3.3; alpha 1 globulin - 0.4; alpha - 20/9; beta 1.1; gama 1.8; serum iron 40 mg./100 ml.; TIBC - 345; latex negative; ANF negative; salicylate level - 21. Chest x-ray negative; X-rays of knees, elbows negative. X-ray of hip demonstrates charmlly-

type arthroplasty with otherwise normal features although tomograms had to be taken to exclude pelvic fracture.

X-rays of hands demonstrated extensive loss of cartilage in the right radial carpal and intra carpal joints with destructive changes involving the carpal bones and loss in volume of the carpus in general. There was also loss of cartilage in the right 3rd, 4th and left 4th MP joints with destruction of sub-chondral bone.

X-ray of feet demonstrated loss of cartilage in the right 1st MP joint with hallus valgus.

Course and Treatment: The patient was treated with physiotherapy and rest.

Naprosyn in a dose of 250 mg. TID, was added to her therapeutic regime. Intra-articular steroids were injected into the active ankle, the right wrist, the two afflicted MP joints and the three inflamed PIP joints. The grip was only 20 on admission had improved to 80 by the time of discharge.

Ophthalmologic consultation was obtained. Myopia was noted.

There were no toxic effects from the Chloroquin therapy. Iron therapy was instituted on account of a low serum iron. The patient was considerably improved at the time of discharge and the function in the right arm was much better.

Discharge Medications:

Myochrysine 50 mg. weekly

Chloroquin 250 mg. OD daily at night

Prednisone 5 mg. BID
Entrophen 325 mg. 1/4 tabs QID
Naprosyn 250 mg. TID
Ferrous Gluconate 300 mg. TID
Codeine 60 mg. in am. p.r.n.

The investigator, unable to disclose any further information from the Scarborough General Hospital, contacted the Toronto East General Hospital's medical records department and was informed:

Patient hospitalized in January of 1971 for an incomplete abortion under Dr. M. A D&C was done during this hospitalization. Hospitalized in July of 1972 with diagnosis of rheumatoid arthritis; therapeutic abortion; fibro-adenoma of breast under Dr. M. The fibroadenoma of the breast was excised.

Hospitalized in May of 1973 for rheumatoid arthritis under Dr. T.

Hospitalized in September of 1973 for rheumatoid arthritis and secondary degenerative arthritis left hip. A left total hip replacement was done by Dr. B.

Hospitalized in 1974 for a therapeutic abortion under the care of Dr. M.

The investigator then contacted the Etobicoke General Hospital, medical records department and was informed that no information could be obtained without written authorization.

The investigator, unable to disclose any further information in regards to the Claimant's medical background, subsequently made discreet inquiries in regards to the Claimant's financial background and was informed that the Claimant is married to . No employment is listed for either.

The Claimant came on file in January of 1976 with a chattel mortgage registered with GMAC in Toronto for the amount of \$5,532.00 which expires in December of 1978.

In January of 1977, it shows another chattel mortgage registered with the Canadian Imperial Bank of Commerce for the amount of \$4,153.00 which expires in December of 1979.

The investigator was unable to disclose any further trade nor derogatory reports in regards to the Claimant.

The investigator, after numerous attempts, subsequently contacted the Claimant's place of employment in Barrie, Ontario and was informed by the Manager that the Claimant had been working for her for a few days in a part-time position for the last week selling wigs.

The investigator was informed that the Claimant had previously worked for the company in Toronto and had left to have a child.

The investigator subsequently made numerous inquiries at [employer's office] in Toronto, Ontario but at this time has been unable to obtain any information in regards to the Claimant.

The investigator subsequently discontinued to complete reports.

By letter dated March 17, 1977, Mr. Bonner forwarded to Commercial Union Assurance Company of Canada the Centurion report. The covering letter contained this statement:

We instructed Centurion Investigation Ltd. to obtain further information as to the injuries sustained by the Claimant and their report is attached which is self explanatory.

Despite Mr. Bonner's repeated denials that he had ever asked Centurion Investigation Ltd. to provide medical information, the

evidence points to the inescapable conclusion that he did do so. The paragraph set out above is part of that evidence and the receipt of 18 other investigation reports, each containing substantial medical information, supports the conclusion that Mr. Bonner expressly retained Centurion Investigation Ltd. to obtain medical information from physicians or their employees and hospitals, which Centurion Investigation Ltd. did in fact provide and for which it was paid.

On April 7, 1976, a motor vehicle insured by Eaton Insurance Company (now Eaton/Bay Insurance Company) was involved in a collision which caused damage and injuries to a claimant. The adjusting of this claim was assigned by an adjuster employed by Eaton Insurance Company to Mr. Bonner. On December 14, 1976, Mr. Bonner telephoned Centurion Investigation Ltd. and, according to that company's records, instructed it to obtain "medical" information. Mr. Bonner denied that he had given that instruction. Mr. Bonner knew that an experienced Hamilton solicitor, John Agro, Q.C., had been retained by the claimant. Mr. Agro had undertaken to forward all medical information to Mr. Bonner once it had been assembled. It is eminently reasonable, in these circumstances, to conclude that Mr. Bonner did request Centurion to be "discreet".

Similarly, in file 4153, the claimant was represented by a solicitor. Mr. Bonner retained Centurion Investigation Ltd. to do an investigation and the Centurion record indicates instructions from Mr. Bonner to be "discreet". I am satisfied that Mr. Bonner did instruct Centurion Investigation Ltd. to be discreet because he did not want the solicitor who had been retained by the claimant to know that he had asked for medical information about his client.

On May 14, 1976, a motor vehicle insured by the Eaton Insurance Company was involved in a collision causing damage and injury to the claimant. An Eaton employee, Dorothy Pankhurst, assigned the adjusting of this claim to Mr. Bonner who, in turn, on December 6, 1976, orally instructed Centurion Investigation Ltd. to obtain "medical" information. Mr. Bonner placed a \$100.00 limit on the investigation. Centurion Investigation Ltd. confirmed this assignment to obtain medical information and the \$100.00 limit. In due course, Centurion Investigation Ltd., by letter dated January 12, 1977, addressed to Mr. Bonner, provided the following report:

WEDNESDAY, DECEMBER 8, 1976

The investigator received case instructions from our office in regards to this investigation.

THURSDAY, DECEMBER 9, 1976 to TUESDAY,
DECEMBER 21, 1976

During this time the investigator made numerous discreet enquiries in regards to the Claimant's medical background and subsequently disclosed from Toronto East General Hospital, Emergency Department, that the Claimant, on May 14, 1976, had x-rays taken in regards to a cervical spine in the emergency department. The results of the x-rays showed no significant abnormality. The investigator was advised that the Claimant's emergency file number in regards to the accident is _____.

During this time the investigator also discreetly disclosed from Dr. Z, the Claimant's family doctor, that the Claimant has a notation in medical file, that no information is to be disclosed without proper written authority.

During this time the investigator disclosed that the Claimant is believed to be employed at the City of Toronto Fire Department. His date of birth is _____ and he is married to .

During this time the investigator made further discreet enquiries in regards to the Claimant's medical background but was unable to disclose any information to assist this investigation.

An account for \$100.00 accompanied this report and on January 13, 1977, Mr. Bonner questioned this \$100.00 account and requested a breakdown of the cost involved. By letter dated January 18, 1977, Mr. McGarry wrote to Mr. Bonner as follows:

As per your telephone conversation dated January 13th, 1977 in regards to an invoice breakdown relating to this investigation.

The investigators cost is relaying the information to the confidential source and further attempts to achieve the information required to complete this investigation total \$65.00's.

The confidential source cost is attempting to achieve the information required to complete this investigation \$35.00's.

Total cost \$100.00's.

If I can be of any further assistance to you in regards to this situation please contact me at my office.

The \$100.00 account was paid in due course by Eaton Insurance Company. In his evidence, in answer to Mr. Strosberg, Mr. Bonner had this to say:

It has never been suggested to me and I have no knowledge of it, that Centurion paid people for information.

However, he ultimately admitted that the only interpretation that could be placed on the letter of January 18, 1977, was that someone must have been paid by Centurion Investigation Ltd. to release information that ought not to have been released. Mr. Bonner went on to say that he had no knowledge of any improper conduct on the part of Centurion Investigation Ltd.

I cannot accept that denial. The most reasonable interpretation that the letter of January 18, 1977, can be given is that Mr. McGarry was informing Mr. Bonner that \$35.00 had been paid to someone to provide medical information. I believe that when he received this letter in January, 1977, Mr. Bonner took for granted, as part of the accepted practice in the insurance investigation industry, that health information was received from confidential sources who had an obligation to keep information confidential and that he simply did not consider this practice improper. I will deal later with the question of the alleged payments for medical information. On a fair reading of all of the reports received from Centurion Investigation Ltd. directed to him, Mr. Bonner must have known that an unauthorized review of the medical records had taken place since, in the letter of January 18, 1977, he was expressly told that payment had been made for such information and, accordingly, he knew how Centurion Investigation Ltd. obtained health information.

It may well be that Mr. Bonner never directed his mind to the questions of impropriety and did not ask how Centurion Investigation Ltd. obtained health information. Had he asked, I have no doubt that he would not have received an honest answer, since the investigators' common viewpoint was that the client was entitled to know the results of an investigation but not the

manner in which the information had been obtained. His failure to focus on this impropriety was illustrative of the myopia of the whole industry which had come to expect the receipt of health information, improperly obtained, as a matter of right.

Mr. Bonner's understanding of the propriety of the practice of obtaining health information without authorization was revealed in the following exchange at the hearing:

A. I said I wasn't aware it was improper.

MR. STROSBERG: Well, I'm sorry, but the first thing that you told me, the first thing that you told me on Thursday was that you knew that doctors had a duty not to release medical information without the patient's consent. Did you tell me that?

A. Yes.

Q. That you always accepted that principle?

A. Yes.

Q. That a nurse or anyone who worked with a doctor's office had the same duty not to release information without the patient's consent and you said that you always accepted that principle?

A. Yes.

Q. That a hospital had a duty to keep the information confidential and not to release the information without the consent of their patients and you said that you accepted that principle and always had accepted that principle?

A. Yes.

Q. That anyone who worked there, that was where you said to me what about this fellow who swept the floors and you said that even he had an obligation to keep the information confidential. That you always accepted that principle?

A. Yes.

Q. That you considered it would be improper for an adjuster to encourage or promote a doctor or a nurse or a hospital employee to breach their duty by releasing that confidential information without consent?

A. Yes.

Q. That you always accepted that principle?

A. Yes.

Q. It would be improper for an adjuster to have his employees cause a nurse or a doctor or a hospital employee to breach that obligation of confidentiality?

A. Presumably.

Q. That you always accepted that principle?

A. Yes.

Q. On the face of all those statements, sir, how can you say that you didn't know that it was improper to ask Centurion to provide a report when you knew in all probability that they would be giving you a report which contained information from hospitals and doctors that was obtained without the consent of the patient?

A. Because I just didn't think about it at the time.

Q. Had you thought about it, would you have considered that it was improper for you to do that?

A. In retrospect, yes.

The evidence of Mr. MacFarlane was frank and to the point. His acknowledgement, on his own behalf and on behalf of the company and employees, was to the following effect:

1. That hospitals and their employees, and physicians and their employees had an obligation to keep the contents of health records of patients confidential ("principle of confidentiality") and this was and is a subsisting and recognized principle.
2. That the company and its employees ought to have known that the principle of confidentiality subsisted and recognized and accepted it.
3. That the evidence given by Mr. Bonner made it appear to Mr. MacFarlane that the company employees in the course of their duties, instructed Centurion Investigation Ltd. to carry out investigations, knowing that eventually it would obtain confidential medical information from hospitals, physicians or their offices without the consent of patients.
4. That the 21 Centurion reports delivered to MacFarlane & Associates contained confidential medical information from hospitals or physicians and were received by MacFarlane & Associates' employees in the course of their duties and utilized in the evaluation of claims or for setting reserves.
5. That it was his present view that Centurion Investigation Ltd. ought not to have been retained.
6. That the obtaining of confidential medical information without the patients' consent violated the principle of confidentiality.
7. That as a matter of corporate policy MacFarlane & Associates agreed that confidential medical information ought not to be sought or received by the company, its servants, agents or employees from investigators without the patients' prior consent; and

8. That as a matter of corporate policy the company accepted the principle of confidentiality and undertook to co-operate further with the Commission whenever requested.

The Hartford

Hartford Fire Insurance Company, Hartford Life Insurance Company and London Canada Insurance Company carry on business, in Ontario and elsewhere, under the name, The Hartford. In Ontario, among its other interests, The Hartford carries on the business of a casualty insurer. The Hartford was a client of Centurion Investigation Ltd. Our investigation uncovered 14 files in which health information had been sought or received by employees of The Hartford. A typical example follows. On February 7, 1977, Centurion Investigation Ltd. was instructed to carry out an investigation. A confirmation was forwarded by Centurion Investigation Ltd. to an employee of The Hartford, confirming that it was to:

carry out an investigation relating to:
past employment - activities - photos -
credit (financial) - medical

The Centurion file contains the following memorandum:

February 10/77

O.H.I.P. pretext call to subject home -
spoke with male who identified himself as
subject
-family doctor - H
-also seen Dr. M
-never been admitted to hospital
-seen in ER at North York General

It was the practice of Centurion Investigation Ltd. to have the employees making pretext calls put their initials on the outer cover of the file. On this file, the initials R/M are shown - the initials of Ruth Mendelsohn - and the date February 8, 1977, is given. The memorandum indicates that Ruth Mendelsohn used the OHIP pretext and, by it, obtained particulars of the family physician, specialist, and hospital attended by the subject. By letter dated February 28, 1977, Thomas McGarry reported to The Hartford. His letter read, in part, as follows:

As per your instructions, we have conducted investigations and observations on the above captioned, , hereinafter referred to as the Claimant and submit our report to date.

A report was enclosed which, again in part, said:

FRIDAY, FEBRUARY 11, 1977 to MONDAY, MARCH 7, 1977

During this time the investigator made numerous discreet enquiries in relation to the Claimant's financial and medical background.

The investigator did a financial background enquiry in relation to the Claimant, which shows the Claimant still residing at Toronto, Ontario and his employment listing as .

The Claimant's previous employment is shown as . The Claimant came on file in 1970. The last enquiry was in February 1977 from an oil company. In June 1976 a department store account was checked, which was opened in June, 1976, balance \$13.00, rated I-1. In October 1976 a department store was checked, account opened in July 1974, balance \$94.00, rated R-4. In October 1976 a bank was checked, account opened in October, 1976, no high credit, balance \$400.00 rated R-1. In December, 1976, checked bank card which was opened in 1974, high credit \$1,091.00, balance \$1,001.00, rated R-1. In January 1977 the bank was checked, account opened in August 1976, loan was taken out for \$2,745.00, terms of payment were \$114.00 over 24 months. In December 1976 a bank account was checked, a PCA opened in 1974, medium 3 figure balance and rated satisfactory.

The investigator made further discreet enquiries, but was unable to disclose any further trade or derogatory reports in regards to the Claimant.

The investigator made enquiries in regards to the Claimant's medical background and

contacted the North York General Hospital and was informed that they have no record of the Claimant having been treated there, nor have they any x-rays on file of the Claimant.

The investigator contacted the office of Dr. H, a general practitioner and was informed that the Claimant had x-rays taken at North Toronto Medical Building as follows:

January 20, 1976 - Cervical spine x-ray: There is some narrowing of the disc space at the C6-7. Slight anterior bony spurring. There is also a slight spurring at C5-6. But, the disc space is not narrowed. There is no encroachment on the invertebral foramina and no fracture is seen.

April 23, 1975 - Lumbar Spine x-ray: Films were made of the lumbar-sacral spine. Bone density is normal. There is no evidence of fracture or dislocation. The lumbar disc spaces are well maintained. The sacral-iliac joints are intact.

The investigator was informed that the Claimant has been a patient of Dr. H for many years. The investigator was informed that the Claimant's file starts in 1975, since the doctor moved and changed location. The investigator was also informed that a report to the doctor from the Toronto Physiotherapy Centre reads: Initial findings on presented on March 22, with complaints of constant neck pain ... physiotherapy. The investigator subsequently made further enquiries in relation to the x-rays that were taken in April 1975 but was unable to disclose any information without written authorization.

The investigator contacted the office of Dr. Mc an orthopedic surgeon, and was informed that the Claimant was seen only once at this office, on September 29, 1976. A report written by Dr. Mc, dated October 2, 1976 in regards to the Claimant, and written to the attention of Dr. H reads as follows:

This man has chronic neck and low back discomfort, arising out of a motor vehicle accident in January of this year. Prior to the accident, he was healthy and working as an advertising writer. He was the driver of a car that was struck from behind and extensive damage was done to his car. He has had neck discomfort being the most significant. There is no historical or clinical suggestion of any nerve root involvement. He maintains a good range movement in his neck and low back, with appropriate tenderness in the muscles and ligamentive structures of these regions. I think his problem is one of simple muscle strain and muscle spasm that is continuing. I have suggested some chiropractic treatment and have pointed him in the direction of a reasonable practitioner of the art. If his problem persists beyond the next few months, I would appreciate seeing him again.

The investigator unable to disclose any further information in relation to the Claimant's background, subsequently discontinued to complete reports.

The words "numerous discreet inquiries" appear throughout the Centurion reports. The expression is a euphemism for pretext. Upon reading the contents of any Centurion report, any recipient would conclude that some improper method had been used to obtain the information it contained. A review of all 14 files leads to the inescapable conclusion that The Hartford's employees retained Centurion Investigation Ltd. to obtain health information without authorization when they knew that this information was being obtained improperly.

In May, 1978, Samuel Brian McNabney was the Regional Claims Manager for The Hartford and had been in that position for 18 months. He had been associated with The Hartford for 17 years in its claims department. In May, 1978, Gordon Voutt was the assistant general manager for The Hartford and had occupied that post for 18 months. He had been associated with The Hartford for 19 years in a capacity not related to claims. Both

Mr. McNabney and Mr. Voutt, personally, and on behalf of The Hartford, and The Hartford's employees acknowledged that:

1. Hospitals and their employees and physicians and their employees have an obligation to keep the contents of the health records of the patients confidential ("the principle of confidentiality") and this was and is a subsisting and recognized principle.
2. The Hartford and its employees knew or ought to have known the principle of confidentiality subsisted and was a recognized principle and ought to have accepted that principle.
3. The Hartford and its employees in the course of their duties instructed Centurion to carry out investigations when they knew or ought to have known that Centurion Investigation Ltd. during the investigation would obtain confidential medical information from hospitals or physicians without the consent of the patient.
4. Centurion investigation reports containing confidential medical information from hospitals or physicians were received by The Hartford's employees in the course of their duties and utilized in the evaluation of claims or for the setting of reserves.
5. Centurion Investigation Ltd. ought not to have been retained, as the obtaining of confidential medical information without the patient's consent violated the principle of confidentiality.
6. The Hartford accepted as a matter of corporate policy that confidential medical information ought not to be sought or received by the company, its servants, employees, agents and investigators without the patients' prior consent.

Mr. McNabney testified that, as an annual average, The Hartford dealt with approximately 1,350 bodily injury cases. His estimate was that investigation reports were obtained in approximately seven per cent of these bodily injury cases. The Hartford undertook to continue to co-operate with us and provided us with reports from four other investigation agencies which engaged in practices similar to those of Centurion Investigation Ltd.

Federal Insurance Company

Federal Insurance Company is a casualty insurance company which carries on business in Ontario and elsewhere. In our investigation we located 13 files in cases in which employees of Federal Insurance Company sought or received health information from Centurion Investigation Ltd. As an illustration, and at the risk of repetition, I shall describe one situation in which Centurion Investigation Ltd. was instructed by an employee of Federal Insurance Company to obtain medical information.

On June 19, 1976, a motor vehicle insured by Federal Insurance Company struck the rear of another vehicle causing back injury to a claimant. On June 28, 1977, an employee of Federal Insurance Company instructed Centurion Investigation Ltd. to carry out an investigation and to determine the claimant's medical history before the accident. A confirmation, in writing, was sent by Centurion Investigation Ltd. to Federal Insurance Company.

The instructions to Centurion were not limited in any respect and were not restricted to medical information related to a previous back injury. By letter dated July 15, 1977, Centurion Investigation Ltd. forwarded the following report:

THURSDAY, JUNE 30, 1977

The investigator received case instructions from our office in regards to this investigation.

The investigator commenced enquiries in regards to this investigation.

MONDAY, JULY 4, 1977 to WEDNESDAY, JULY 13, 1977

During this time, the investigator, through confidential sources and discreet enquiries, subsequently disclosed the following information in regards to the Claimant's medical

background. The investigator disclosed from the Henderson General Hospital, Medical Records Department that the Claimant's first name is according to her medical records. The records also disclose the following information relating to the Claimant:

Records show the patient's OHIP number to be . The patient's first admission to this hospital was in 1965. However, those records are on micro-film and I do not have the diagnosis available.

The patient was admitted to the hospital in November, 1968 for an anal fissure. An excision of the anal fissure was done.

The patient was admitted to the hospital in October, 1969 with a diagnosis of viral pneumonitis and gastritis. X-ray of the chest was normal. A Barium Meal and cholecystogram were done and the results were normal.

The patient was admitted to hospital in October, 1972 for viral blue and lumbar disc disease. No x-rays were taken on this admission.

The patient was admitted in December, 1973 with an admitting diagnosis of iron-deficiency anemia and cervical spondylosis. The following x-rays were done and were all normal: chest, barium enema, barium meal and oral cholecystogram. An x-ray of the cervical spine showed degenerative changes at C5-6, C6-7 levels. Moderate osteoarthritis.

The patient was admitted to hospital in July, 1975 with a diagnosis of possible Parkinson syndrome; possible M.S.; and anxiety-neurosis.

A skull x-ray was done and the report showed the examination to be within normal limits. X-rays of the cervical spine, lumbar spine, and thoracic spine were done and all the x-rays were normal.

The patient was admitted to hospital in February, 1976 for rectal bleeding and iron-deficiency anemia.

The patient's last admission to this hospital was in November, 1976 for removal of the right Fallopian tube.

The investigator disclosed from the St. Joseph's Hospital, Medical Records Department, the following information relating to the Claimant:

"The patient had had admissions to this hospital in 1952, 1954, 1958 and 1964. However, all of these records are on microfilm. The diagnosis for these admissions are not available.

The patient's last admission to this hospital was in October 1972. She was admitted to the hospital on October 25, 1972 with a diagnosis of multiple disc degeneration, L3-4-5; spinal stenosis, acute metabolic encephalopathy; and temporary low potassium.

A total laminectomy and foraminotomies were done at L4 and S1. A partial laminectomy was done at L2-3.

The following x-rays were done:

'Chest: allowing for slight rotation, no abnormality of the heart or lungs.

Echogram: no shift of mid-line structures.

Electroencephalogram: this is a borderline record showing an excess of slow activity suggestive of a toxic or metabolic disturbance. There is no evidence of any epileptogenic focus nor is there any epileptic activity seen during the recording. There is no evidence of a subdural haematoma, brain abscess, or other space-occupying lesion.'

The patient was discharged from the hospital on November 14/72."

The investigator disclosed from the office of Dr. L, OBS./GYN., office located within the [address], Hamilton, Ontario, that the Claimant's date of birth is . Also that the Claimant has been seeing Dr. L since 1952.

She has had a laparoscopy and a hysterectomy done in the past. She has an anal fissure and right now she's having some problems with her bowels.

The patient was last seen on March 8/77 for a problem with gas and hemorrhoids.

The investigator was unable to disclose any information from the office of Dr. T, General Practitioner, office located at [address], Hamilton, Ontario, because the doctor is presently on vacation and will not be returning until the first part of August, 1977.

The investigator was unable to disclose any information from the office of Dr. R. MICHAEL HARRISON, G.S. and O.S., office located at 25 Charlton Avenue East, Suite 202, Hamilton, Ontario without proper written authority.

This report was paid for in due course by Federal Insurance Company. An examination of the contents of the report reveals a substantial amount of medical information entirely irrelevant to

a claim for a back injury. The fact that the claimant had undergone a hysterectomy, had suffered from rectal bleeding, iron deficiency anemia, had undergone a laparoscopy and had had an anal fissure demonstrates the extent to which irrelevant medical information had been obtained by Centurion Investigation Ltd., delivered to clients and received without comment.

In May, 1978, Ronald MacDonald had been the regional claims manager of Federal Insurance Company for 10 years. He had been associated with that company in a claims capacity for 25 years. Peter Smith, the chief agent of Federal Insurance Company, also appeared to give evidence. The chief agent is the chief legal officer for the company in Canada. Mr. Smith was also the regional vice-president for the company and was responsible for operations in Ontario and western Canada. He had held the chief agent's position for six months and had been the regional vice-president for 10 years.

Mr. MacDonald and Mr. Smith, personally, and on behalf of Federal Insurance Company and its employees, acknowledged that:

1. Hospitals and their employees and physicians and their employees have an obligation to keep the contents of the health records of the patients confidential ("the principle of confidentiality") and this was and is a subsisting and recognized principle.
2. Federal Insurance Company and its employees knew or ought to have known the principle of confidentiality subsisted and was a recognized principle and ought to have accepted that principle.
3. Federal Insurance Company and its employees in the course of their duties instructed Centurion Investigation Ltd. to carry out investigation when they knew or ought to have known that, during the course of investigation, it would obtain confidential medical information from hospitals or physicians without the consent of their patients.
4. Centurion investigation reports containing confidential medical information from hospitals or physicians were

received by Federal Insurance Company employees in the course of their duties and utilized in the evaluation of claims or for the setting of reserves.

5. Centurion Investigation Ltd. ought not to have been retained, as the obtaining of confidential medical information without patient consent violated the principle of confidentiality.
6. Federal Insurance Company accepted as a matter of corporate policy, and this policy was confirmed by the New Jersey head office, that confidential medical information ought not to be sought or received by the company, its servants, employees, agents and investigators without the patients' prior consent.

The Wawanesa Mutual Insurance Company

The Wawanesa Mutual Insurance Company, more commonly known simply as Wawanesa, is a casualty insurance company which carries on business in Ontario. Our investigation revealed 10 files in cases in which Wawanesa's employees requested Centurion Investigation Ltd. to obtain, or in which they received, health information without patient consent or authorization. I shall give three examples which support my conclusion that Wawanesa's employees retained Centurion Investigation Ltd. with the intention and expectation that it would obtain confidential health information without the authorization of patients.

Centurion Investigation Ltd. received a pre-printed assignment form from Wawanesa, dated May 26, 1977, requesting it to determine the claimant's "type of injury". Centurion Investigation Ltd. interpreted this request to be one which required medical information. Its report, which had been dictated by James McGarry, was accompanied by a covering letter dated June 10, 1977, addressed to Wawanesa. The report was in the following language:

WEDNESDAY, JUNE 1, 1977 to JUNE 7, 1977
During this time the investigator, through confidential sources and discreet enquiries, subsequently disclosed the following information relating to the Claimant's medical background:

Date of Birth:

O.H.I.P.

Family Doctor:

The Claimant had been hospitalized at Doctors' Hospital approximately 13 years ago in regards to an operation on her legs. The Claimant has been suffering from a bone problem.

The Claimant was hospitalized in the Wellesley General Hospital approximately 3 to 5 years ago, under the care of Dr. U, who is an Obs./Gyn.

The Claimant is also seeing a Doctor B. Berris, 600 University Avenue, Toronto, Ontario.

The Claimant is seeing Doctor Joseph S an orthopedic surgeon, at [address], Toronto, Ontario.

The investigator contacted Doctors' Hospital Medical Records Department and learned that the only records they have on file for the Claimant are from 1963 and that is on microfilm and any information from these records could only be obtained with the proper written authorization.

The investigator disclosed from the office of Dr. U the following information:

The patient was first seen in 1975 for atrophic vaginitis. In March 1976 a D & C was done for post-menopausal bleeding which failed to reveal any malignancy. The patient was last seen in September 1976 for atrophic vaginitis. There is no summary on the patient's file as she was not a consultation. There was a few notes on her chart, but they are in the doctor's own writing.

The investigator disclosed from the office of Dr. E, a general practitioner, [address], Scarborough that the Claimant had suffered a

whiplash injury approximately 5 years ago and one more in April 1977. The Claimant's x-rays show a small amount of degenerative disc disease and osteoporosis. The Claimant was advised to have physiotherapy, take valium prn. and wear a collar prn. The doctor has only seen the Claimant on three occasions but otherwise she has been in good health. The doctor only treated the whiplash injury. The doctor is a friend of a friend and was very reluctant to take the Claimant on as a patient.

The investigator disclosed from the office of Dr. S that the Claimant's file was marked medical/legal and therefore no information could be released without proper written authority.

The investigator was unable to disclose any information without proper written authorization from the office of Dr. Barnet Berris.

The investigator made further inquiries, but was unable to disclose any further information at this time.

On June 9, 1977, Wawanesa instructed Centurion Investigation Ltd. to ascertain a claimant's "type of injury and medical information." By letter dated June 24, 1977, Thomas McGarry reported to Wawanesa:

The investigator made discreet enquiries in relation to the Claimant's medical background and contacted the office of Dr. B, a general practitioner, [address], Rexdale, Ontario. During the conversation Dr. B stated:

I have been the patient's family doctor since 1968. She has not had any serious illnesses or health problems in the past, other than diabetes. She is a juvenile diabetic. She has been a difficult child at home. There have been numerous family problems, financial and emotional upsets, between her and her parents. More than the

natural amount of rebellion that happens in many teenagers.

She had a recent accident on May 26, 1977. She had headaches following the accident. There is a big functional component with her. My opinion is that the headaches are due to the accident. I did not take any x-rays as I didn't think they were warranted. I didn't give her any type of therapy and she was not off work. I saw her on May ... hit by a drunk driver apparently. She had aching in her neck and left shoulder, upper back, chest and headaches. Certain movements of her neck were tender and painful and she was complaining of a headache. She might warrant an x-ray of her cervical spine, but the fact that she was able to work indicated to me that probably these symptoms were not all that severe. I felt that it was a thing that would resolve spontaneously within a reasonable time. She is able to work and she wasn't complaining unduly the last time I saw her, which was on June 3, 1977. I really didn't think x-rays or therapy was warranted. She is on Entrophen and Dyazepam which I believe Dr. G has put her on at some stage.

The investigator, unable to disclose any further information from the office of Dr. B, discontinued the conversation and contacted the office of Dr. G, the internist, [address], Toronto, Ontario. Dr. G informed the investigator that he has only treated the Claimant for diabetes, and nothing else and that no further information could be obtained without written authorization.

The investigator then contacted the York-Finch General Hospital, Medical Records Department and the Emergency Department and

was informed that they have no record of the Claimant having ever attended at this hospital.

The investigator contacted the Etobicoke General Hospital, Medical Records Department, and was also informed that no information could be obtained without written authorization.

The investigator contacted the X-ray Film Library of the Etobicoke General Hospital, and was informed that on May 26, 1977 the Claimant had x-rays taken of the left shoulder, lumbar spine, and cervical spine. The reports read as follows:

The x-ray of the left shoulder is normal. The x-ray of the Lumbar Spine shows a very minimal degenerative disease of the lumbar spine is present, with anterior osteophyte formation. A slight scoliosis to the left in the mid-lumbar spine region is noted. The remainder of the examination is normal. Opinion: Minimal degenerative disease of the cervical spine with anterior and posterior osteophyte formation, most marked in the mid-cervical region, is demonstrated. The remainder of the examination is normal. Opinion: Minimal degenerative disease as described.

The investigator, also at this time, disclosed that the Claimant's date of birth is , and her O.H.I.P. .

The investigator, unable to disclose any further medical information in regards to the Claimant, subsequently made discreet enquiries in relation to the Subject's employment background.

The investigator contacted (office equipment sales) and was informed that the Claimant has worked with this company for approximately 5 years as a secretary and is a very

reliable employee. The investigator continued enquiries, but was unable to disclose any further information at this time.

The medical information contained in this report was obtained by Miss Mendelsohn by the use of pretext calls. She lied to the claimant's general practitioner that she was calling from the offices of "Dr. Martin, Neurologist".

Wawanesa's instructions to Centurion Investigation Ltd. were given with the intention that it should obtain medical information without the claimant's authorization. The words "discreet enquiries" in the report meant that a pretext or some other impropriety had been used. The report to Wawanesa even expressly states that information could not be obtained from the Etobicoke General Hospital, Medical Records Department, without written authorization of the patient. The fact that the instructions to Centurion Investigation Ltd. were made on a pre-printed form strongly suggests that Wawanesa did a volume business with Centurion. Wawanesa's employees had obtained this sort of information from Centurion Investigation Ltd. on other occasions and I am persuaded that they knew it was being obtained on a regular basis.

While riding his bicycle, a 13-year old boy was struck by a motor vehicle insured by Wawanesa. It asked Centurion Investigation Ltd. to determine the boy's "exact injuries, his present status and prognosis and whether any artificial supports would be required." This assignment came from Wawanesa's London office. Despite the knowledge by both companies that the child and his parents had retained a solicitor, the 13-year-old claimant was visited by a Centurion investigator at his home. A description of the infant's injuries was obtained. This visit was not alluded to in the Centurion report to Wawanesa dated September 9, 1979. That report read as follows:

During this time, the investigator through discreet inquiries and confidential sources, disclosed the following information relating to the Claimant:

The Claimant, as a result of this accident was hospitalized in the War Memorial Children's Hospital, London, Ontario, and discharged on July 29th, 1977. His injuries consisted of 2 broken elbows, a broken femur, a bruised lung, and a concussion. The investigator was advised by the

confidential source that the Claimant's medical file is still active, therefore no further information can be obtained at this time.

Centurion Investigation Ltd. did not have a "confidential source" in the War Memorial Children's Hospital in London, or, for that matter, in any hospital. The term "confidential source" was used throughout its reports. Internally, to Centurion employees, "confidential source", meant information obtained from an unknown person or from a known person by the use of a pretext.

James McGarry testified that the words "confidential source" were not used to mislead the client into believing that Centurion Investigation Ltd. had a source, i.e. a person with whom there was a special relationship, who provided the information. To him, the expression "confidential source" meant simply that a pretext call had been made. He said that he believed that clients did not know that pretext calls were made to obtain health information. No one, to his knowledge, at Centurion Investigation Ltd. had ever explained to the clients exactly how the subjects' medical histories were acquired. I am sure that the words "confidential source" were used to mislead clients into believing that Centurion employees were able to obtain information the clients themselves could not obtain because of a supposed relationship the employees had with the persons in a position of access to the confidential health information. Eventually Mr. McGarry conceded, and I accept his concession, that anyone reading a Centurion report would conclude that the health information given had been obtained by Centurion investigators in some improper manner. What is very significant is that no customer of Centurion Investigation Ltd. ever complained about, or took issue with, the manner in which that information had been obtained.

James McGarry attempted to justify the practice of obtaining health information by the methods I have described by reasoning that if the purpose for which the information was being obtained was a legitimate one, for example, to enable an insurance company to settle a claim, the method of obtaining the information was irrelevant. It could not be considered improper because the end justified the means. He believed that a resort to improper means, if it was for a "good" purpose, made the improper means proper. I need hardly say that I reject this rationalization. It is an entirely unacceptable solution to the problem of reconciling conflicting interests. In short, it is a position that cannot be justified.

In May, 1978, Michael Joseph Brousseau had been the Claims Manager for Wawanesa Mutual Insurance Company in Ontario for two years. On behalf of himself, Wawanesa, and Wawanesa's employees, he acknowledged that:

1. Hospitals and their employees and physicians and their employees have an obligation to keep the contents of the health records of the patients confidential ("the principle of confidentiality") and this was and is a subsisting and recognized principle.
2. Wawanesa and its employees knew or ought to have known the principle of confidentiality subsisted and was a recognized principle and ought to have accepted that principle.
3. Wawanesa and its employees in the course of their duties instructed Centurion Investigation Ltd. to carry out investigations when they knew or ought to have known that, during the investigations, it would obtain confidential medical information from hospitals or physicians without the consent of the patient.
4. Centurion investigation reports containing confidential medical information from hospitals or physicians were received by Wawanesa's employees in the course of their duties and utilized in the evaluation of claims or for the setting of reserves.
5. Centurion Investigation Ltd. ought not to have been retained, as the obtaining of confidential medical information without patient consent violated the principle of confidentiality.
6. Wawanesa accepted as a matter of corporate policy that confidential medical information ought not to be sought or received by the company, its servants, employees, agents and investigators without the patients' prior consent.

Mr. Brousseau testified that, on an average yearly basis, Wawanese dealt with 2,500 bodily injury claims in Ontario and that in approximately five per cent, or 125, of these cases investigations reports had been obtained.

Reserves

Mr. Brousseau explained that every time an insurance company has notice of a possible claim against one of its insured persons it must "set a reserve". A reserve is a sum of money that an insurer is required to set aside to meet the contingency of a successful claim. It includes an estimate of the cost for hospital and medical expenses incurred, an amount for general damages for pain and suffering and loss of amenities of life, an amount for other out of pocket expenses such as loss of wages, and an amount for legal costs to be paid to the claimant's solicitor and to the insurer's solicitor. It was Mr. Brousseau's estimate that it was only in 15 out of the annual total of 2,500 cases that employees of Wawanese had obtained medical information without authorization. This was, he said, only a small fraction of the reserves that were required to be set. He frankly admitted that it would not be a hardship to Wawanese to do without confidential health information. Certainly Wawanese would be able to carry on business successfully without continuing the practice of obtaining medical information without authorization.

The encouragement of the settlement of personal injury claims is sound public policy. The need for medical information on the part of the insurer in the settlement process must be recognized. That need can be accommodated, however, without violating a claimant's privacy. Settlement is a mutual affair, and a claimant who wants to settle will provide the insurer, the real party opposed in interest, with medical information about himself or herself or with an authorization for the release of that information. If he or she does not, there will be no settlement.

CNA Assurance Company or The Citadel

With respect to the need of an insurer for medical information obtained without a claimant's authorization, the opinion of Mr. Brousseau was echoed by Douglas Charles Grigg, the senior examiner of the CNA Insurance Company. CNA Assurance Company was an insurance company which had been taken over by a Swiss conglomerate on February 1, 1977, and thereafter became known as The Citadel.

Two investigation reports containing medical information were received by CNA Assurance Company. I accept the explanation tendered to Mr. Strosberg that medical information was neither sought nor desired by CNA. Mr. Grigg testified, and I accept his testimony, that as a matter of corporate policy medical information was never sought without authorization and that neither he nor any other employee of CNA knew that Centurion Investigation Ltd. would obtain medical information.

Mr. Grigg said that he had been setting reserves for approximately 30 years and that, in his opinion, it was unnecessary to obtain medical information without the consent of the patient to set the reserves. He was generally able to set a reserve based on the length of time the file was outstanding, the description of the injury given in the police report, physical evidence of the injury, surveillance reports and any medical information, if any, tendered by the lawyer acting for the claimant.

The Waterloo Mutual Insurance Company

The Waterloo Mutual Insurance Company, which I shall refer to as Waterloo Mutual, is a casualty insurer. Its head office is in the City of Kitchener but it carries on business throughout the Province of Ontario. Waterloo Mutual was a client of Centurion Investigation Ltd. Our investigation turned up six investigation reports made to Waterloo Mutual. Centurion Investigation Ltd. was retained by Waterloo Mutual to obtain confidential medical information about claimants, in the expectation that Centurion Investigation Ltd. would obtain medical information and with the knowledge, on the part of the employees of Waterloo Mutual, that there was no authorization which would permit the release of that information.

For example, on the 1st day of December, 1976, Waterloo Mutual instructed Centurion Investigation Ltd. to acquire information about the extent of a claimant's drinking habits, his relationship with the Welfare Department and any previous medical problems. These instructions were confirmed by a memorandum to Waterloo Mutual by Centurion Investigation Ltd. Waterloo Mutual eventually received a report which it paid for in due course and which contained the following information:

Mr. Jasper stated that he knew the Claimant and drank with him often. The investigator, unable to disclose any further information in regards to the Claimant, subsequently

discontinued the conversation to complete reports.

THURSDAY, FEBRUARY 10, 1977 to THURSDAY,
MARCH 10, 1977

During this time the investigator made numerous discreet enquiries in relation to the Claimant's medical background and contacted the office of Dr. I, a neurosurgeon. Dr. I stated:

He's a chronic alcoholic. We operated on his ulnar nerve in the left elbow in 1970. He was on welfare at the time and that's the only time we ever saw him.

The investigator continued enquiries, but was unable to disclose any further information, without written authorization.

The investigator contacted the office of Dr. L a general surgeon and was informed that there was no record of the Claimant having ever been treated by Dr. L.

The investigator contacted the office of Dr. Is, an orthopedic surgeon. The investigator was informed that the Claimant had a fractured left hip. He had a motor vehicle accident in March 1974 and was last seen in September 1974. The investigator made further enquiries and was informed that no further information would be disclosed without written authorization.

The investigator contacted the office of Dr. H a general practitioner and was informed that Dr. H first saw the Claimant when he fractured his left hip. He had been in a car accident. Dr. H stated:

I was on call and he didn't have a doctor in town. He had a fractured left hip which was grossly comminuted and displaced. It was fixed with a pin - or a sliding nail, I guess they call it.

He added:

He got home. He tripped and refractured the same hip. Gradually he healed. He was also being seen by Dr. Is, the orthopedic surgeon and he was in the hospital until September 1974. I have not seen him since that time, in fact, I never did see him in the office, only in the hospital.

The investigator, unable to disclose any further information from Dr. H, contacted the Kitchener/Waterloo Hospital, Medical Records Department and was informed that the Claimant was first seen in the Emergency Department in 1974 for chest pain. An x-ray of the chest was taken at that time, which showed considerable chronic chest disease. The patient's first admission to this hospital was on March 24, 1974. He had been struck by a car and had a fractured left hip. He was seen by Dr. H and Dr. Is, during his admission. There is no discharge summary written for that admission. The patient was transferred to Freeport Hospital on April 26, 1974 for rehabilitative care.

The patient was subsequently re-admitted to this hospital in 1974 (September) for a re-fracture of the left hip. Again, under Dr. Is. On discharge, Dr. Is wrote the following:

He will continue with his crutches. I will reassess him in approximately 3 weeks. It will be a total of three months before he will be able to put weight on his lower left extremity.

The Claimant was last seen in this hospital in May, 1976. This time in the Emergency Department for intoxication. The report read as follows:

Looks and smells of alcohol, having had one bottle of wine.

The investigator was informed that there is no family doctor listed on the Claimant's file. On the Emergency record for this last visit, the patient stated that he did not have a family doctor.

The investigator, unable to disclose any further information from the Kitchener/Waterloo Hospital, contacted the Freeport Hospital, Medical Records Department and was informed that the Claimant has had only one admission to this hospital. He was transferred to Freeport Hospital from Kitchener/Waterloo Hospital on April 26, 1974, with admitting diagnosis of multiple injuries from a motor vehicle accident, chiefly a fractured left hip. The Claimant was under the care of Dr. H. A copy of the letter sent to Freeport Hospital when the Claimant was transferred, was written by Dr. Is and is dated March 25, 1974 and reads as follows:

Reason for admission - multiple injuries, secondary to motor vehicle accident. This is a man who varies his age between 53 and 63 years. He is more in keeping with 63. He was involved in a motor vehicle accident on King Street in Waterloo in the area of the Waterloo Theatre. He apparently was crossing King Street when he was struck by a car. He was not unconscious. He can remember from immediately before being hit, lying on the road, and being brought to the emergency department.

He complains of pain in the left hip area, basically.

Medical: No heart disease, no diabetes.

Surgery: Excision of abscess from right elbow a number of years ago.

A knife wound, anterior chest.
Hemorrhoidectomy.

Medications: None.

Allergies: None.

Physical Examination: Head and Neck
- Head reveals that he has multiple abrasions over his face. There is a large abrasion over the anterior frontal area which is about 3 inches in diameter but is superficial. There is no evidence of any fracture of the facial bones.

Chest: Reveals clear air entry bilaterally. I could not detect any fractured ribs.

Abdomen: Soft, non-tender. Liver and spleen are not enlarged. Bowel sounds were present.

Neurological: He was oriented as to time and place and person. He was slightly obtunded, but I think this is just in keeping with his normal personality. His pupils did not react to light, greatly due to the fact that he has had Demerol.

Cranial nerves 3, 4, 5 and 6 were unremarkable. He was moving all of his extremities, except the left lower which is in traction.

Musculo-skeletal: Examination of left lower extremity reveals that he has a swelling of the anterior upper thigh area with associated laceration about 1 inch in length over the upper lateral aspect of the thigh. He has a clinical fracture. There were no neuro-vascular problems distal to this fracture.

Plain x-rays of the chest and skull reveal no significant abnormalities.

X-ray examination of the left hip reveals a severely comminuted fracture with displacement.

Admitting Diagnosis: Multiple injuries with fractured left hip.

Plan of Management: After initial resuscitation, he will be taken to the Operating Room.

The patient was transferred to Freeport for rehabilitative care. He was discharged home on July 4, 1974.

The investigator, unable to disclose any further information in relation to the Claimant's medical background, subsequently discontinued to complete reports.

Again, on February 11, 1977, an employee of Waterloo Mutual instructed Centurion Investigation Ltd. by telephone to carry out an investigation. A note in the Centurion file shows that this employee informed Centurion Investigation Ltd. that, at the time of the accident, the claimant may have lost a baby and asked Centurion to determine whether that was, in fact, the case. A written confirmation was sent to Waterloo Mutual to confirm that a "Medical" was to be done or obtained.

In due course, Centurion Investigation Ltd. forwarded an investigation report dated March 17, 1977 to Waterloo Mutual as follows:

The investigator, unable to disclose any further information in relation to the Claimant's employment background, contacted the Kitchener/Waterloo Hospital and was informed that the following x-rays had been taken of the Claimant: March 9, 1977 the Claimant had a G.I., gall bladder, chest and sinus x-ray. Prior to that, in 1972 the Claimant had an arthrogram.

The investigator made further enquiries to learn that the Claimant was admitted to the hospital on the following dates: February 14, 1976 to February 20, 1976 in relation to the Claimant's pregnancy; April 18, 1975 the

Claimant was admitted for a D & C; on February 3, 1976 the Claimant was admitted for false labour.

On April 18, 1975 a history was written by Dr. O, which read as follows:

This 32 year old, granida #2, para #1, who being admitted with a diagnosis of incomplete abortion. She had her last period on February 19, 1975 and had some spotting and the pregnancy test was positive on April 10th. However, the pregnancy test is negative today. She has been an infertility problem and has been on various drugs trying to get her pregnant. She appears to be in good health otherwise.

Examination: Chest is clear to percussion and auscultation, heart sounds normal, BP 110/70, weight 140 pounds. Past illnesses - tonsillectomy. She had one child in 1961 November. No family history of diabetes TB or allergies. The uterus, on examination is enlarged about 6 to 8 weeks. There is blood in the vagina and admix clear. She is admitted with a diagnosis of incomplete abortion and will have a D & C today.

The investigator made further discreet enquiries at the Kitchener/Waterloo Hospital to learn that they have no record of the Claimant had been admitted previously and no record for her having been treated in the Emergency and no incomplete abortion.

The investigator contacted the office of Dr. Adelburg, who informed the investigator that no information could be obtained without written information.

The investigator, unable to disclose any further information in relation to the Claimant's medical or employment background

at this time, subsequently discontinued and completed reports.

Waterloo Mutual was given notice of our hearings, provided with copies of all relevant documents and had the opportunity to participate, to do so by counsel, and to call evidence. It did not avail itself of the opportunity to call evidence, although represented by counsel. No explanation of the material was made. I draw the inference, as I have suggested, that Waterloo Mutual's employees and, through them, Waterloo Mutual itself, retained Centurion Investigation Ltd. intending it to obtain confidential health information without the claimant's authorization and knowing that they were not entitled to obtain that information.

Bennett & Seaman Insurance Adjusters Inc.

Bennett & Seaman Insurance Adjusters Inc., which, for convenience, I shall call Bennett & Seaman, is an adjusting firm which carries on business in the City of Kitchener and elsewhere. Bennett & Seaman was a client of Centurion Investigation Ltd. Our investigation produced six investigation reports which had been sent to Bennett & Seaman and in which medical information had been sought and received. In all of these cases Centurion Investigation Ltd. had been instructed to obtain medical information about claimants, in the knowledge that no authorization had been given to permit the release of that information. In fact, some of the assignments were made when the adjuster was dealing with the claimant's solicitor.

On February 7, 1977, William Miller of Bennett & Seaman instructed Centurion Investigation Ltd. to carry out an investigation into the activities and medical background of two claimants who were represented by a senior Toronto lawyer, Kenneth Howie, Q.C. Mr. Howie appeared at our hearings on several occasions and made it clear that, in all circumstances in which he was involved as a plaintiff's solicitor, he made full disclosure of the medical information in his possession to the adjuster and the solicitor for the defendant in order to facilitate the settlement of his client's claim promptly and fairly. Despite Mr. Howie's well known reputation for this practice, Mr. Miller felt it necessary to instruct Centurion Investigation Ltd. to obtain this information. It will be enough to illustrate the relationship between these two companies with one example. On March 7, 1977, Mr. Miller received a report from Centurion Investigation Ltd. which, in part, read as follows:

After approximately one hour, the investigator observing no further sign of the Claimants or any activities to assist this investigation, discontinued to complete reports.

MONDAY, FEBRUARY 21, 1977

The investigator made discreet enquiries in relation to the Claimants and disclosed that the Claimants and their family have two children, a boy 5 years old and a girl 1 1/2 years old.

In October of 1975 Claimant #1 quit his job at , as an Assistant Manager. He is presently employed with the Post Office as a letter carrier and works out of different postal stations and commences work at 6:00 a.m., Monday through Friday and usually finishes work at approximately 3:00 p.m. The Claimant's wife is not employed.

The investigator, unable to disclose any further information in regards to the Claimant, discontinued to complete reports.

TUESDAY, FEBRUARY 22, 1977 to SATURDAY,
MARCH 5, 1977

During this time, the investigator made discreet inquiries in relation to the Claimant's medical background. The investigator contacted the office of Dr. W, an orthopedic surgeon, and was informed that Dr. W had treated Claimant No. 1 at the Wellesley Hospital Clinic for a motor vehicle accident and the last time that Dr. W seen the Claimant No. 1 was August of 1976.

The investigator was informed that all the records are at the Wellesley Hospital because Claimant No. 1 was not treated at Dr. W's office.

The investigator, unable to disclose any further information from the office of Dr. W, contacted the office of Dr. W. Mueller, located at 597 Parliament Street, Toronto, Ontario and was informed

that no information could be obtained without written authorization.

The investigator subsequently contacted the Wellesley General Hospital Medical Records Department and was informed that no information could be obtained without proper written authority.

The investigator contacted the X-ray Department of the Wellesley Hospital and was informed that the following X-rays were taken of Claimant No. 1.

On January 14th, 1977, a left femur X-ray. The investigator was informed that some of the films had been lost in the operating room so only a lateral view is present and reads as follows.

It shows that intramedullary nail has been removed. There does appear to be good callus formation in the middle third of the femur, opposite of the previous fracture. Considerable soft tissue calcification and ossification is present about the patella. But the wire sutures have been removed.

The left femur X-ray taken in November of 1975 of Claimant No. 1 reads as follows.

There is evidence of a transverse fracture through the shaft of the left femur of the middle proximal third. There is also evidence of a comminuted fracture of the left patella with rather marked separation of the inferior pole from the body of the patella.

The investigator made further discreet inquiries in relation to both Claimants medical background but was unable to disclose any further information at this time and subsequently discontinued to complete reports.

William Fletcher Seaman, a principal of Bennett & Seaman, attended our hearing and, in his testimony, made an acknowledgment of "the principle of confidentiality" in the now familiar form.

Aston Associates Limited

Aston Associates Limited, which I shall refer to as Aston, is a private investigation company which carries on business in the City of Toronto. The primary shareholder of this company is Kenneth Maslen. Our investigation disclosed five situations in which Mr. Maslen, on behalf of Aston and his clients, retained Centurion Investigation Ltd. as a subcontractor. Mr. Maslen paid Centurion Investigation Ltd. to do surveillance work and to obtain medical information. Mr. Maslen knew that Centurion Investigation Ltd. obtained this information without the claimant's authorization and that Centurion was retained expressly because there was no authorization cannot be in doubt. Each of the assignment sheets to Centurion bears a note indicating that Centurion Investigation Ltd. was to obtain medical information. All of the investigation reports directed to Aston contained substantial medical information. For example, by letter dated December 13, 1976, Mr. McGarry reported to Mr. Maslen about a claimant, a passenger in a motor vehicle involved in an accident on June 21, 1976. The report contained the following information:

The investigator conducted background enquiries in relation to the Claimant's medical background and learned the following:

The Claimant's wife injured her back in 1972 and was paid by Workmen's Compensation Board. Is still having problems with her back and left leg.

The Claimant was in Sunnybrook Hospital under the care of Dr. P for close to 4 years.

In relation to the motor vehicle accident of June 1976, the Claimant saw Dr. R and received no treatment either in the emergency or hospital, or by the doctor following the accident.

The investigator made enquiries at Sunnybrook Hospital, Medical Records Department in relation to the Claimant to learn the following:

Was hospitalized in Sunnybrook Hospital January 20 to 31, 1974 under Dr. P, Internist.

A copy of the history and summary written by Dr. P on the Claimant, dated January 31, 1974 is as follows:

Final Diagnosis:

- (1) rheumatic heart disease with aortic stenosis and aortic insufficiency,
- (2) possible mitral stenosis,
- (3) esophageal reflux,
- (4) hepato-diaphragmatic interposition of the colon?

Forty-three year old Yugoslavian real estate salesman with one half year history of epigastric right upper quadrant pain. This pain is a burning sensation - does not radiate, not affected by meals, did not seem to be any aggravating or relieving factors. Pain has awakened him at night. He has not tried antacids to relieve the pain. He has had an upper GI series 2-3 months ago that apparently was normal. Denies nausea, vomiting, hematemesis, melena, diarrhea, constipation. Does not smoke. Does drink up to 3-4 glasses of whiskey per day, especially during social events. Denies any ASA ingestion. Is on no medication. Drinks 1-2 cups of coffee per day.

Functional Enquiry: Complains of a small area of skin over the right costal margin and the right upper quadrant which is parasthetic. No other complaints. No other diseases. No allergies.

History of Past Illnesses: He had rheumatic fever as a child. He has not had any surgery. No other

illnesses. Has taken no medication in the past.

Family History: Father and two uncles operated on for ulcers.

Physical Examination: Forty-three year old robust male. No apparent distress. Examination of eyes, pupils, fundi, extra ocular muscles, normal. Oral pharynx examined, normal. Lungs were resonant to percussion, clear to auscultation. Examination of cardiovascular system - blood pressure 120/80. Pulse, 70/min. regular. Jugular veins were not distended. No evidence of edema. Peripheral pulses were palpable bilaterally. Auscultation s 1 increased in intensity, s 2 normal. At rest, grade 2 over 6 systolic ejection murmur heard best at the left sternal border. On exercise, an opening snap and a diastolic rumble could be heard.

Examination of abdomen, soft and non-tender. Liver edge palpable at the right costal margin. There was a cylindrical hard mass 4 cm. below the left costal margin at the mid-clavicular line. It is attached to underlying muscle and not attached to the skin, most likely a lipoma. He says that it has been growing slowly for the last 10 years. There is an area of paresthesia on the skin in the right upper quadrant and over the right costal margin from the xiphoid out to the mid-clavicular line.

Rectal examination, normal. Neurological examination, normal.

Hemoglobin, hematocrit, white blood count, ESR, all normal. Routine urinalysis, normal.

ECG showed non-specific ST-T wave changes. SGOT slightly elevated at 26 units. Alkaline Phosphatase normal at 101 units. Total bilirubin normal at 0.7 mg. but direct bilirubin elevated at 0.4 mg. Serum electrolytes, BUN, creatinine, calcium, phosphorus, all normal.

Stool examination for occult blood three times and trace amounts were found.

BSP don, normal.

Chest x-ray, normal. X-ray of thoracic vertebrae, normal. X-ray of lumbar vertebrae showed anterior osteophytes at L3 and L4.

Upper GI series showed reflux in the distal esophagus. No other abnormalities.

Barium enema showed that the hepatic flexure is located very high in the abdomen. No evidence of sinking or obstruction.

Liver scan, normal.

It is possible that his symptomatology is caused by the reflux into his lower esophagus. It is also possible that there is subdiaphragmatic interposition of the colon and that the colon becomes temporarily obstructed in the hepatic flexure occasionally.

Patient discharged with no medication.

Enquiries were made at Dr. R's office, but he only opens his office for one hour, several days per week. The information will be obtained, but probably within the next week, and will be forwarded on to the client.

Morden and Helwig Limited

Morden and Helwig Limited is in the independent adjusting business with offices throughout Ontario. It was a client of Centurion Investigation Ltd. We discovered five of the latter's investigation reports addressed to Morden and Helwig Limited. It retained Centurion Investigation Ltd. to obtain health information knowing that the claimants had not authorized the release of that information.

For example, on September 8, 1976, an employee of Morden and Helwig Limited was involved in negotiations to settle a personal injury claim with a claimant's solicitor. It is probable that because the solicitor seemed eager to settle the claim that this employee suspected that the claimant might have a terminal illness. He therefore retained Centurion Investigation Ltd. and asked it to determine the following:

- a) how the claimant was progressing,
- b) whether he would have to use a cane,
- c) whether he had any previous illnesses or problems with his legs, and
- d) whether he had a terminal illness such as cancer, etc.

On September 19, 1976, Centurion Investigation Ltd. reported the following information:

Upon arrival the Investigator was advised that the Claimant was presently receiving therapy.

The Investigator observing that the Claimant would not be finished the therapy for approximately two to three hours, discontinued and proceeded to complete reports.

MONDAY, SEPTEMBER 27, 1976

The Investigator, acting on a suitable pretext, proceeded to the St. John's Convalescent Hospital and subsequently observed the Claimant within his room.

The Investigator observed that the Claimant is described as male white, approximately 80 years of age, approximately 5'3" in height,

weighing approximately 120 pounds with white hair, wearing very thick glasses.

The Claimant was dressed in a shirt and casual slacks.

The Investigator observed the Claimant within his room as he was sitting, within a chair near his bed.

He had his right leg and foot extended on a foot rest nearby.

The Investigator observed the Claimant as he raised his right leg and foot and crossed it over his left leg in an apparent normal manner.

The Investigator noted that the Claimant's right knee appeared to have a support bandage around it as the bulge in this area seemed to indicate.

During the Investigator's discreet pretext conversation, he advised the Investigator that he had been involved in a motor vehicle accident in March of 1976 at which time he was taken to the Sunnybrook Hospital where he was advised that he had a fractured knee and a ruptured bowel.

He related that he was operated on and given treatment and then released near the end of April of 1976.

He related that he was able to get around with the aid of two canes which he still uses about the hospital.

He advised the Investigator that he returned to the Hospital after approximately two weeks because of infection within his injured knee.

He advised the Investigator that it appears that he had developed Parkinson's Disease and is presently receiving treatment for it.

He related that the last time that he was in the Hospital was approximately forty years ago.

The Claimant seemed to indicate that it was the Sunnybrook Hospital he was in.

He advised the Investigator that he expects to be released from this Hospital in approximately four weeks time.

The investigator unable to disclose any further information to assist this investigation discontinued and proceeded to complete reports.

During the Investigator's discreet observations the Claimant was observed sitting, occasionally turning his head, neck and shoulders from left to right and on two occasions raise his right leg and foot and cross them over his left leg.

During the Investigator's observations the Claimant did not appear to show any signs of physical pain or restrictions.

The Investigator did observe two walking canes within the Claimant's room.

By letter delivered to us on October 12, 1978, Morden and Helwig Limited made an acknowledgment in the same terms as that made on behalf of The Hartford which is reproduced above. It is my conclusion that Morden and Helwig Limited's employees retained Centurion Investigation Ltd. intending it to obtain confidential health information without the claimant's authorization knowing that they were not entitled to obtain that information.

The Dominion of Canada General Insurance Company

The Dominion of Canada General Insurance Company, a casualty insurer which carries on business throughout Ontario was another client of Centurion Investigation Ltd. We found four Centurion investigation reports directed to The Dominion of Canada General Insurance Company. Three of those files indicate that the employees of The Dominion of Canada General Insurance Company asked for confidential medical information knowing that

the claimants had not authorized the release of that information. For example, an employee of the Dominion of Canada General Insurance Company in Waterloo on January 6, 1977, instructed Centurion Investigation Ltd. to carry out an investigation of a claimant injured in a motor vehicle collision on March 13, 1976. In accordance with its usual practice, Centurion Investigation Ltd. forwarded a confirmation of assignment with a note that it intended to carry out an investigation to obtain "medical information including any previous injury." By letter dated February 18, 1978, Centurion Investigation Ltd. forwarded its report which contained the following information:

THURSDAY, JANUARY 6, 1977

The investigator received case instructions from our office in regards to this investigation.

FRIDAY, JANUARY 7, 1977 to WEDNESDAY,
FEBRUARY 9, 1977

During this time, the investigator made numerous periodical observations and inquiries at the Claimant's place of residence located at , Ontario, but was unable to observe the Claimant or any activities.

During this time, the investigator made numerous discreet inquiries in relation to the Claimant's medical background and contacted the St. Mary's Hospital medical records department, Kitchener, Ontario and was informed that the Claimant was treated in the emergency room on March, 1976 when she was involved in a motor vehicle accident and her face was struck.

She sustained the following injuries: painful swelling in the left cheekbone, laceration of the lip sutured with 5-0 nylon. X-ray of facial bones done showed no fractures. Treated by Dr. Y, the Casualty Officer and released.

The investigator, unable to disclose any further information from St. Mary's Hospital, contacted the office of Dr. S, a General Practitioner and was informed that the Claimant was first seen by Dr. S in the office on March, 1976. The Claimant had

been involved in a motor vehicle accident on March, 1976. Dr. S has been treating the Claimant for whiplash and strain of the neck.

On May 4th, 1976, Dr. S sent a letter to her lawyer which reads as follows:

Had lacerated upper lip; Hematoma on left side of face; pain in the neck muscle, headache and pain in her back. Lacerations were sutured. Hematoma of face was quite painful. Her main complaint was headache, soreness and stiffness of the neck muscles. She had considerable limitation of movement of her head to either side as well as forward or backward. She had difficulty holding her head up for any length of time without experiencing severe pain and headache. She was prescribed a cervical collar then. (March 13th, 1976 in the emergency room at Hospital).

At her last visit to see me prior to writing this letter May 1976, she was able to remove the collar for short periods during the day but had to put it on again after approximately two hours.

The patient had X-rays done of the facial bones in August of 1976 and those were negative.

The doctor's been seeing regularly - several times a month, for treatment of the whiplash since the accident. He had her on Fiorinal C 1/2. She was last seen in the office on January 10th, 1977, again for diagnosis of whiplash injury. (No further note was made on the patient's condition at that time).

The investigator, unable to disclose any further information from the office of

Dr. S, made discreet inquiries at the office Dr. I, an Orthopedic Surgeon and was informed that it was a medical/legal case and that Dr. I did not treat the Claimant but only did an assessment on her for the insurance company.

The investigator was informed that no information could be obtained without written authorization.

The investigator, unable to disclose any further information in regards to the Claimant's medical background, made discreet inquiries in relation to the Claimant's employment background and contacted , located at , Ontario and spoke with the owner/manager who informed the investigator that the Claimant was not a full-time employee but she was classified as part-time being on call to do work as it was available for her to do.

The Claimant was employed as a seamstress.

The investigator was further informed that the Claimant, when called upon to work, was always available and never refused work duties due to illness or injury. She always worked a full day from 9:00 a.m. to 5:00 p.m. being paid \$3.50 per hour. The last date on which the Claimant worked was March 12th, 1976. The Claimant's income tax T-4 slip for 1975 recorded a gross salary of \$2,199.04.

The Claimant's income for 1976 up to March 19th, 1976 was \$1,358.90.

The investigator was also informed that the Claimant's earnings for 1976 were up substantially from those of 1975 due to an increase in business thus she could have expected to earn more in 1976.

The Claimant did not return to work after March 12th, 1976 due to a motor vehicle accident which she had on March 13th, 1976.

I have formed the conclusion from a study of the reports that the employees of The Dominion of Canada General Insurance Company retained Centurion Investigation Ltd. intending it to obtain confidential medical information about claimants knowing that they had not authorized the release of that information and knowing that they were not entitled to it.

Northland Crawford Insurance Adjusters Canada Ltd.

Northland Crawford Insurance Adjusters Canada Ltd., which I shall call Northland Crawford, carries on the business of an insurance adjuster throughout Ontario. Northland Crawford was also a client of Centurion Investigation Ltd. We found four Centurion reports addressed to Northland Crawford. I need give only one example.

On June 8, 1976, a Northland Crawford employee instructed Centurion Investigation Ltd. to carry out an investigation of a claimant who had been injured in a motor vehicle collision on November 3, 1975. He asked for medical information. Utilizing the pretext that the OHIP computer had broken down, Centurion Investigation Ltd. learned the names of the attending physicians from the claimant and, in due course, reported as follows:

MONDAY, AUGUST 2, 1976 to TUESDAY, AUGUST
10, 1976

During this time, the investigator discreetly disclosed the following medical in regards to both Claimants.

The investigator was advised from Dr. H's office that the doctor is still treating both Claimants in regards to whiplash injuries sustained in a motor vehicle accident which occurred on November 3, 1975.

The investigator was advised by the doctor's secretary that both Claimants attend the doctor's office once a month, also that they are both receiving physiotherapy treatments, in regards to medication given to the Claimants; Claimant #1 is taking Percadon and Valium. Claimant #2 is taking Valium.

The investigator was advised that their medical files do not indicate Dr. H's opinion as to the severity of their whiplash

injuries, also, there is no indication within the files that the doctor has referred them to an orthopedic surgeon.

The investigator was advised that if any x-rays had been taken of the Claimants they would have been done at the Dixie X-ray Clinic.

The investigator subsequently contacted the Dixie X-ray Clinic and discreetly learned that there were no x-rays on file of Claimant #1 and the only x-ray on file for Claimant #2 is in regards to a chest x-ray.

At this time, the investigator was advised that the Dixie X-ray Clinic has another location, the investigator subsequently contacted this location and was advised that there were no x-rays on file in regards to either Claimant.

The investigator subsequently contacted Dr. R's office and discreetly learned that the only information in regards to either Claimant is that Dr. R had removed Claimant #1's tonsils several years ago. The investigator subsequently made further discreet inquiries, but was unable to disclose any information to assist this investigation.

Centurion Investigation Ltd. was retained by Northland Crawford's employees expressly to obtain confidential medical information about claimants, knowing that the claimants had not authorized the release of this information, and knowing that they were not entitled to obtain this information.

Other Clients of Centurion Investigation Ltd.

It will be recalled that the investigation files of Centurion Investigation Ltd. which we seized under the authority of a search warrant in the course of our investigation were those which came into existence during the period of August 15, 1976 to March 1, 1978. By no means did we have all of its files. As a result, it cannot be said that we examined all of its transactions with all of its clients. It was only a sampling of transactions that were reviewed. All of the companies mentioned below were clients of Centurion Investigation Ltd. and

all of them requisitioned and received investigation reports containing confidential health information obtained without the authorization of the claimant. Every one of these clients, through an appropriate officer, made the following acknowledgment:

1. Hospitals and their employees and physicians and their employees have an obligation to keep the contents of the health records of patients confidential ("the principle of confidentiality") and this was and is a subsisting and recognized principle.
2. Their company and its employees knew or ought to have known the principle of confidentiality subsisted and was a recognized principle and ought to have accepted that principle.
3. Their company and its employees in the course of their duties instructed Centurion Investigation Ltd. to carry out investigations when they knew or ought to have known that during the investigations it would obtain confidential medical information from hospitals or physicians without the consent of the patients.
4. Centurion investigation reports containing confidential medical information from hospitals or physicians were received by their company's employees in the course of their duties and utilized in the evaluation of claims or for the setting of reserves.
5. Centurion Investigation Ltd. ought not to have been retained, as the obtaining of confidential medical information without the patient's consent violated the principle of confidentiality.
6. Their companies accept as a matter of corporate policy that confidential medical information ought not to be sought or received by the company, its servants, employees, agents and

investigators without the patients' prior consent.

These companies were the following:

<u>Company</u>	<u>Officer Representing</u>
Fireman's Fund Insurance Company previously known as Shaw and Begg	William Cunningham
Canadian General Insurance Company	
Gore Mutual Insurance Company	John Grant Nearingburg
Markel Service Canada Limited	Donald W. Ross
Adamson's Insurance Adjusters Limited	Paul Bracken

Insurance Company of North America, more frequently referred to as INA, was another client of Centurion Investigation Ltd. An acknowledgement made by INA in writing was filed as an exhibit at our hearing.

Lawyers

Several lawyers used the services of Centurion Investigation Ltd. For convenience, I shall discuss the involvement of lawyers later in the report.

OHIP as a Source of Health Information

On October 19, 1975, a motor vehicle insured by The Hartford Insurance Company struck and killed a pedestrian in Ottawa. The Hartford's insured did not see the pedestrian before the collision and believed that the pedestrian may have jumped out in front of him. The pedestrian was alleged to have said to a cab driver, immediately before the accident, that he was tired of living and wished to end it all. On October 6, 1976, a Hartford employee telephoned Centurion Investigation Ltd. and asked it to develop background information aimed at determining whether the deceased had been suicidal, had been seeing a psychiatrist, had had marital or financial problems or had had children in trouble.

By letter dated December 16, 1976, another Hartford employee wrote Centurion Investigation Ltd. as follows:

Under date of October 6, 1976, our Mr. made a telephone call to your office requesting that an investigation be completed on one Mr. (deceased). This investigation was to include detailed background information of the deceased with emphasis on any information that could be developed to support suicidal tendencies on behalf of the deceased individual.

Under date of November 26, 1976, the writer made a telephone call to your office requesting that the information gathered to date be forwarded, as the matter is presently in litigation and this information would be helpful in determining our present position, with regards to liability. To date, this has not been received and we would appreciate if we could receive the information developed to date, at your earliest possible convenience.

This matter was assigned, eventually, to Wayne John Stewart, a field investigator employed by Centurion Investigation Ltd. Mr. Stewart, as an experienced Centurion investigator, was aware that medical information was being obtained by means of pretext calls to physicians' offices and hospitals. He had observed these calls being made and had discussed the making of such calls with all the McGarry brothers and knew that the pretext calls were made with their full knowledge, direction and approval. By letter dated December 31, 1976, Daniel McGarry sent an investigation report to The Hartford in the following language:

WEDNESDAY, OCTOBER 13, 1976 to TUESDAY,
OCTOBER 26, 1976

The investigator conducted background enquiries in relation to marital problems, results negative. Also conducted enquiries in relation to financial problems, and learned that the financial situation is quite stable, no listed derogatory reports or trade in relation to financial difficulties, no bankruptcies, civil actions, nsf cheques, or any other problems in relation to financial.

The investigator then conducted enquiries in relation to children or relatives having difficulties, negative results.

The investigator enquired in relation to Ottawa Civic Hospital, Medical Records, and was only able to disclose from the files, which are presently being held in a special file, re enquiry, the following:

The Claimant was never admitted to the hospital. Died within 3/4 of an hour on arrival at hospital through multiple injuries.

The investigator conducting medical background enquiries, learned the following in relation to the Claimant's wife, . Her OHIP number is . Her family doctor is Dr. L, telephone . She has only been hospitalized once for treatment and this was in the Scarborough General Hospital, between June 6, 1976 and June 9, 1976 inclusive, under the care of Dr. Mc.

The investigator, through confidential sources and discreet enquiries learned the following: Dr. L has been treating Mrs. for several years now, and lately has been following up after Dr. Mc did a cone biopsy and cauterization. This was performed June 1976. This showed a class IV Pap smear and she has to have repeat smears done very often (approximately every 3 months). No malignancy has been shown, but constant checks have been made. In April 1976, she was put on Elavil 10mg. Although the husband was killed in October of 1975, she, the patient, has never mentioned her husband's death to Dr. L, nor was there any notation on the records, nor did she try to talk to anyone in the office about it. Dr. L never treated the Claimant and the only patient he had in the family was Mrs. , the Claimant's wife. Her last visit was in October 1976 for a Pap smear.

The investigator conducted investigation at Scarborough General Hospital and the office

of Dr. Mc, who is an obstetritian and gyna-chologist, telephone , and learned that he treated Mrs. in the hospital, between June 6, and June 9, 1976 and he performed a D & C and cone and cauterization. She is receiving follow up care by Dr. L. No further information available.

Although, in the ordinary course, as I have pointed out, Centurion Investigation Ltd. destroyed the field notes from which the report was compiled, in this case Mr. Stewart's field notes were not destroyed. The field notes, in Mr. Stewart's handwriting, contained the following notations:

Wednesday, November 24/76

Met with confidential source and submitted O.H.I.P.# to be checked for doctors names.

Friday, November 26/76

Met with confidential source and received the following information O.H.I.P. # is listed to [name of claimant]. File on [name of claimant] has been "purged, pulled and filed in memoire" and there is no way it can be reactivitated.

Other doctor on record is O. Mr. [claimant] is employed with [name of employer] [address of employer]. No further information is available.

Mr. Stewart testified that he paid between \$75.00 and \$100.00 for this information and similar amounts on approximately six other occasions for similar information. On each of the occasions in which Mr. Stewart paid for information submitted to Centurion, he claimed reimbursement in his expense account for the disbursement as a payment to a confidential source. His belief, a belief which I am sure was fully justified, was, therefore, that all of the McGarry brothers knew that he had been paying money for this type of information.

Mr. Stewart paid money to Ronald Arnold and Timothy M. Jones on at least six occasions. He paid them from \$75.00 to \$100.00 on each occasion. He believed that Mr. Arnold and Mr. Jones obtained their information from James Lilly, Charles Meredith and David Harold ("Ike") Eisenhauer. Mr. Stewart was told by both Mr. Arnold and Mr. Jones that these three individuals were able to obtain information from various places,

including OHIP. Mr. Stewart believed that Mr. Lilly and Mr. Eisenhauer had "contacts" at OHIP from whom they were able to obtain confidential information for a fee. He was not sure whether Mr. Meredith had such a contact. Messrs. Eisenhauer, Meredith and Lilly were well known in the insurance industry as persons who had contacts at various places, including OHIP, which they utilized to obtain confidential information.

Mr. Stewart worked for Centurion Investigation Ltd. from May, 1973, until April, 1976, and from October, 1976, until the time of the hearing in May of 1978, approximately a total of 55 months. Mr. Stewart testified that he would submit an expense account on the average of once or twice a month in which he claimed reimbursement for a payment, either in cash or kind, to a confidential source for information. This practice was one that was generally accepted and condoned in the industry and the reimbursement was passed on to the client, who invariably paid the amount claimed.

Ronald James Arnold and Ron Arnold and Associates

Mr. Arnold a licensed private investigator, operated Ron Arnold and Associates Inc., which was incorporated in the year 1975. He admitted that, at all material times, he knew that hospital employees had an obligation to keep health information confidential. Mr. Arnold was retained by insurance companies, adjusters and lawyers. He was, on occasion, requested to obtain, from hospital employees, confidential medical information without the patient's consent. Despite his knowledge that he ought not to seek or to receive that kind of information without consent, he had, personally, from time to time gone to hospitals, identified himself as a private investigator and sought health information. On a few occasions he obtained this information, although he said that he had not indicated to the hospital employees in whose interest he was acting.

Mr. Arnold knew that other investigators made pretext calls to obtain or attempt to obtain health information from hospitals or physicians. He denied, however, that he, himself, had ever made any pretext calls of that sort. He admitted that he had retained others to make them on his behalf since, he said, he was "no good at what they did" because of his broad English accent. It was, unfortunately, impossible to test the truth of these statements by reviewing the file copies of investigation reports prepared by Mr. Arnold because, in November or December, 1977, Mr. Arnold began destroying his files. My inquiry was established by Order-in-Council in December, 1977. Mr. Arnold acknowledged that in February, March and April, 1978, he

destroyed in excess of 60 files containing copies of his investigation reports. He admitted destroying some of these files in April, 1978, when he knew that we were looking into the role that private investigators were playing in the insurance industry in obtaining medical information from hospitals and physicians' offices without consent.

Mr. Arnold testified that he destroyed these files because he was concerned about his clients' confidentiality since the Registrar of Private Investigators and Security Guards, who was also an officer of the Ontario Provincial Police, had exercised his right under section 17(2) of The Private Investigators and Security Guards Act, on two occasions, to designate an officer to "make an inspection of the books, documents and records" of Ron Arnold and Associates Inc. Because of these inspections, Mr. Arnold said, he believed that the confidentiality of his clients had been violated and he had thereupon destroyed all copies of investigation reports and documents such as field notes in his possession. He also admitted that he had destroyed his copies of his accounts to his clients which contained the clients' file number and which, if we had had access to them, would have permitted us to obtain the clients' copies of the investigation report. Mr. Arnold admitted that a concern for confidentiality could not provide a reason for the destruction of these invoices. Without this information, it was impossible to determine the extent to which Mr. Arnold's investigation practices included the obtaining of health information from hospitals and physicians without patient consent because the voluminous records of insurers are kept according to claim numbers and are not indexed alphabetically by the names of their insured or claimants.

In a classic understatement, Mr. Arnold admitted that the destruction of his files would "certainly look suspicious in the mind of a reasonable person" and that it was something that, in retrospect, he ought not to have done. I am satisfied that the destruction of these records was neither in accordance with any usual and accepted business practice nor in accordance with common decency and business morality, but was done to eliminate the possibility of my review of these files and thereby to mask the extent to which Mr. Arnold had obtained, or had someone else obtain, health information without the authorization of the patient during the course of his business. I do not accept Mr. Arnold's statement that he did not believe that our investigation would be interested in his files because he had sought and received health information from hospitals and physicians without authorization. Mr. Arnold's professed concern for the confidentiality of his documents and information was, I have concluded from the evidence, insincere. He admitted that he

knew confidential health information was being obtained by the use of pretexts. He did not care how the information was obtained and as long as it was obtained he did not ask questions. He believed the industry viewpoint to be that nobody cared what means was used to obtain confidential information.

Mr. Arnold admitted that Messrs. Lilly and Meredith were employed by Ron Arnold and Associates Inc. for approximately three months and that during this period he assigned them the task of obtaining medical information from hospitals and physicians' offices without the authority of patients. The exact extent and results of those assignments would have been revealed by the destroyed files. The fees paid to Messrs. Lilly and Meredith were always added as a disbursement to the accounts rendered to the clients. Mr. Arnold said that no insurer had ever asked how the confidential health information was obtained. Moreover he had never gratuitously advised his clients how the information had been obtained. He thought that the insurers would "probably be aghast" had they known how the information was obtained. However, Mr. Arnold went on to say that it was unnecessary for insurance companies to ask where the information came from because anyone who read an Arnold report knew that a trick or some other such means had been used to obtain health information without authorization.

Mr. Arnold denied that Mr. Stewart had ever paid money to him for the purposes of obtaining information from OHIP and he denied ever having a discussion with Mr. Stewart about the obtaining of OHIP information, as Mr. Stewart had testified. He specifically denied receiving money from Mr. Stewart which was to be passed on to any of Messrs. Lilly, Meredith or Eisenhauer as a fee for the obtaining of OHIP information.

I prefer the evidence of Mr. Stewart over that of Mr. Arnold and I conclude that he did, on occasion, pay money to Mr. Arnold, for the purposes of obtaining information from various sources, including, he believed, OHIP.

I am supported in this conclusion by the fact that after Mr. Arnold made the categorical denial that he had received money from Mr. Stewart for the purposes of obtaining health information, the following exchange occurred at the hearing:

MR. STROSBERG: Just so that we put it clearly, are you saying that you don't remember whether or not Stewart gave you money to pass on, in exchange for information from OHIP?

MR. ARNOLD: I think it would be fair to say, yes.

MR. STROSBERG: Yes, so that's fair. You don't remember?

MR. ARNOLD: Yes.

I am persuaded that Mr. Stewart truly believed that Messrs. Lilly, Meredith and Eisenhauer had confidential sources at OHIP who provided them with their information. Mr. Arnold, however, was not under any similar illusion. He described Messrs. Lilly, Meredith and Eisenhauer as "professionals in their own field", professional telephone men, that is, who used the telephone and pretexts to obtain information and who were extremely successful in obtaining information and, certainly, confidential information by pretexts, not by payment to any confidential source of sources.

Timothy M. Jones

Mr. Jones was a licensed private investigator who had been employed by Ron Arnold and Associates Inc. for approximately one and a half years commencing in 1974. As a young man in 1972, he had been employed by Mr. Eisenhauer. It was he, in fact, who introduced Mr. Eisenhauer to Mr. Arnold. He knew that Mr. Arnold retained Mr. Eisenhauer, from time to time, to obtain medical information by the use of pretexts. Mr. Eisenhauer, in Mr. Jones's opinion, was a master at obtaining information by the use of pretext calls by telephone. Mr. Jones knew that Mr. Eisenhauer had obtained confidential health information from various sources, including OHIP, using pretexts. Mr. Jones did not believe that any of Messrs. Eisenhauer, Meredith or Lilly had a confidential source at OHIP.

In November, 1976, Mr. Stewart met Mr. Jones and told him that the young lady doing medical pretexts at Centurion Investigation Ltd. was not discharging her responsibilities to his satisfaction. Mr. Stewart provided Mr. Jones with an OHIP number of a person who was thought to have committed suicide outside Toronto. Mr. Stewart wanted him either to verify that suspicion or obtain medical information. Mr. Jones did not admit that this was the same matter as The Hartford incident, previously described, but I am satisfied that it was. Mr. Jones, in turn, retained Mr. Eisenhauer and in due course Mr. Eisenhauer gave him information which included the word "purged". Mr. Jones admitted that he received from Mr. Stewart,

for this information, \$75.00 which he, in turn, passed on to Mr. Eisenhauer.

Mr. Jones testified that the form in which he passed this information on to Mr. Stewart could reasonably be thought to have indicated that it came from OHIP. He stated that he did not know that the information came from OHIP and denied that he was specifically retained to obtain information from OHIP. I do not accept these statements. Mr. Jones, and for that matter, any reasonable person in his position, must have known with reasonable certainty that Mr. Eisenhauer had obtained the information from OHIP and, moreover, that Mr. Eisenhauer intended to approach OHIP for this information. I conclude that Mr. Stewart paid Mr. Jones \$75.00 for information which Mr. Jones represented to Mr. Stewart came from OHIP.

David Harold Eisenhauer

Mr. Jones testified that David Harold Eisenhauer had obtained the OHIP information which he passed on to Mr. Stewart. Mr. Eisenhauer is a Runyonesque character who provided one of the most enlightening and entertaining moments of our hearings. Known as "Ike" and the "old man" of the locating or skip tracing business, he possesses an expertise in the locating of absconding debtors and missing persons. Almost all of his investigation work is done by telephone pretexts. Approximately five per cent of his work is done by trick mail. For example, he forwards an unsolicited cheque stamped "for deposit only" payable to a debtor and then waits for the return of the cancelled cheque thus discovering the bank in which the debtor has an account. He was retained by creditors, law firms, adjusters and, through them, by insurance companies.

Mr. Eisenhauer gave a remarkably introspective and perceptive account of the investigation industry. He believed that the "real villains" were the people who paid "weak men" like Messrs. Arnold, Lilly, Meredith and himself for their efforts. He cast his cohorts and himself in the role of "victims", although I believe he meant "exploited", and asserted that "most of the blame" belonged to the "masters rather than the servants". He thought that the "perceived dignity" of the insurance industry must be diminished by its readiness to resort to the subculture of which he was a part. Mr. Eisenhauer explained that investigators wanted to make their clients believe that they had paid informers as contacts because this enabled the investigator to pad his account to the customer, since all payments to informers are made in cash.

Mr. Eisenhauer's experience was that clients accepted the fact that cash payments would have to be made to informants from time to time. It was Mr. Eisenhauer's practice to call his client to obtain express authorization before making a payment of that sort. He would never tell a client that he had an OHIP contact but, if the subject arose, he would protest somewhat weakly against such an idea, hoping to leave the impression with his client that he did indeed have such a contact. He expressed the opinion that a client preferred to believe that he had a contact at OHIP and was usually willing to pay for something unlawful. Mr. Eisenhauer acknowledged that, on occasion, he did approach OHIP by pretext to obtain such enrolment data as the home address of a pay-direct subscriber or the name of the employer if the person he was attempting to locate was a member of a group subscription.

In his evidence, Mr. Eisenhauer told of a "secret" telephone number which enabled him to call directly to a "shared time bank" that updated pay-direct subscribers at OHIP. He said, however, that he had destroyed this telephone number in 1973 or 1974 because a friend told him "that the terminal was under surveillance". Mr. Eisenhauer gave what he considered to be a detailed analysis of the way in which the OHIP system operated. It is enough to say that his description bore no relationship to that described in the evidence I later heard from Peat, Marwick and Partners, our consultants, about the operation of the OHIP system. I am satisfied that Mr. Eisenhauer had no access to any such telephone number and no access to any list of updated pay-direct subscribers. I reach this conclusion because of his fanciful description of the system's operation, because no such updated list existed in the years 1973 and 1974, and because in this period OHIP did not share time on any computer. Mr. Eisenhauer admitted that he frequently telephoned OHIP and identified himself as the person whom he wished to locate. I believe that all of his calls to OHIP were made to the public OHIP telephone number designated for subscribers' inquiries. In a typical inquiry, he mentioned the OHIP number (which he had obtained from the person instructing him) and expressed the concern that his employer was not making the required contributions and that therefore he was without OHIP coverage. The person handling the inquiry at OHIP would then begin to discuss the nature of the coverage. By feigning confusion, Mr. Eisenhauer could usually extract the name and address of the debtor's employer and the address of the debtor if he was a pay-direct subscriber. Mr. Eisenhauer said that this technique was common in the investigation field, and was used, for example, by finance companies, banks and private investigators regularly when they were attempting to locate debtors. The OHIP information bank was a favorite source of

information, first, because it was the most up-to-date list of addresses in the Province, second, because even persons who were bad credit risks wanted to keep their OHIP coverage in place, and third, because OHIP as the only primary health insurance coverage available in Ontario, was provided as a fringe benefit by many employers.

Mr. Eisenhauer denied that he had ever contacted OHIP for the purposes of obtaining health information without authorization. He expressly denied that he had provided Mr. Jones with the information previously described in The Hartford incident. Mr. Eisenhauer later withdrew his categorical denial by saying in response to the direct question whether he had given such information to Mr. Jones, that "I cannot remember that." After weighing the conflicting evidence, I have come to the conclusion that I prefer the evidence of Mr. Jones over that of Mr. Eisenhauer, and that, in fact, Mr. Eisenhauer did give the information in The Hartford incident to Mr. Jones. Mr. Eisenhauer was quite glib, and I am sure that he was accurate when he portrayed himself as the "master" in the use of pretext by telephone. I have no doubt that he was able to extract the information in The Hartford incident from an unsuspecting employee of OHIP by a telephone pretext. It is my view that Mr. Eisenhauer had no "contact" at OHIP. I do not believe that Mr. Eisenhauer would pay money to a source for information which he could obtain by his wit.

Mr. Eisenhauer claimed that Mr. Lilly had access to a source of confidential information at OHIP. When he made the allegation there was hostility between the two men. Mr. Lilly had been his protégé but was now his competitor in the skip tracing business and, therefore, I must weigh Mr. Eisenhauer's evidence about Mr. Lilly with caution. I will deal with Mr. Lilly in due course. In the meantime, I conclude that the assertion of a Lilly source at OHIP was simply the act of a member of the subculture "conning" the investigators, to use the jargon that would be used in the trade, and another example of protesting somewhat weakly against the idea of a source in the expectation that the impression would be left that such a source existed. Mr. Eisenhauer asserted that, although he did not seek medical authorization by pretext, Mr. Lilly did, using the name Dr. Hurtzberg. He added that Mr. Lilly frequented taverns in close proximity to OHIP's offices in order to make contact with female employees of OHIP who were less than attractive and who were therefore thought to be more likely to breach their obligation and impart confidential information in exchange for companionship. Whatever drinking habits Mr. Lilly may have had, there was no credible evidence that any such liaisons existed. The assertion is, in my opinion, without merit.

Charles Albert Meredith

Mr. Meredith, who had been licensed under The Private Investigators and Security Guards Act, had his licence revoked in the spring of 1977, at a time when he was employed by Ron Arnold and Associates Inc. Like Mr. Eisenhauer, he was a "telephone man" whose original expertise was the location of absconding debtors. By his own admission, in January, 1977, he began to make pretext telephone calls to hospitals and physicians' offices for the purposes of obtaining confidential health information without patient consent. This work was done by way of subcontract for other investigators. Mr. Arnold promised Mr. Meredith that he would destroy Mr. Meredith's reports after use.

Mr. Meredith and Mr. Lilly worked together and were close personal friends. Mr. Meredith developed a technique of contacting the accounting department of a hospital, representing that he was calling from the audit department and requesting confirmation of an OHIP number. The impression left was that he was, in fact, calling from OHIP and acting in some type of auditing capacity. He dealt with hospitals both within and beyond Metropolitan Toronto and, almost without fail, he succeeded in obtaining confidential information. He also developed the technique of telephoning the medical records department representing that he was calling from the accounting department of the hospital itself. He would change a digit or transpose two digits of the OHIP number and would request such information as the date of the patient's admission to the hospital and the extent of his or her injuries in order, ostensibly, to ensure that he was dealing with the correct individual. Mr. Meredith indicated that all hospital personnel would co-operate because they thought it was an internal call and believed they were simply ensuring that the hospital would be properly credited by OHIP for the care given to the patient.

He used a similar approach to obtain information from physicians' offices, for example, by representing that he was calling from a department of OHIP, distorting the OHIP number and telling a nurse or receptionist that the physician would not be paid unless he was given the required information. At no time, in fact, did Mr. Meredith have a source at OHIP whom he paid to provide information to him. It was his opinion, in the beginning, that his customers believed that he did have such a contact and he deliberately did nothing to dissuade them from this belief.

James David Lilly

Mr. Lilly was another "telephone man" specializing in locating or skip tracing. He learned his trade from Mr. Eisenhauer, with whom he worked from 1971 to 1973. However, as I have already pointed out, the relationship between Messrs. Eisenhauer and Lilly eventually soured. In 1976, Mr. Lilly began working as a licensed investigator for Ron Arnold and Associates Inc. From that time until November, 1977, he obtained confidential medical information for Mr. Arnold, by use of telephone pretexts from time to time. If his instructing investigator did not provide Mr. Lilly with an OHIP number, he would obtain it by telephoning the patient's employer, using the pretext that he was a physician who had just treated the employee and had failed to obtain his OHIP number from him, or phone the wife of the patient, represent that he was calling from OHIP and that the OHIP number was required to process the physician's claim properly.

Mr. Lilly said that he was successful in almost all of his attempts made to hospitals. He was uncertain and vague about the frequency with which these contacts were made. He acknowledged using the pretexts which I previously described in my discussion of Mr. Meredith. I do not believe that Mr. Lilly had a source of information in the offices of OHIP although it may well be that he led fellow investigators to believe that he had such a contact. It was, of course, in his financial interest to have persons in a position to provide him with business think that he was that resourceful.

Messrs. Lilly, Meredith and Eisenhauer often repeatedly obtained enrolment data from OHIP by the use of pretexts. The pretexts used were ingenious and exploited OHIP's system which was set up to deal with subscribers' genuine complaints and problems.

At least on one occasion Mr. Eisenhauer was able to obtain medical information from OHIP by the use of a pretext. The ability of these three individuals to obtain medical information from OHIP was limited. I do not believe that at any time they, or any other investigator associated with Centurion Investigation Ltd., had a relationship with any OHIP employee which resulted in the release of any medical information.

William Kenneth Miller and William K. Miller Insurance Adjusters Inc.

William Kenneth Miller, the president of William K. Miller Insurance Adjusters Inc., is an insurance adjuster with approximately 16 years of experience. He acknowledged that:

1. he had always accepted the principle that a physician had a duty not to release medical information about a patient without that patient's consent;
2. employees of a hospital had a duty to keep confidential the records of hospital patients and not to release the contents without the patients' consent;
3. it was improper for an adjuster to cause, encourage or promote a physician, a physician's employee or a hospital employee to breach this duty of confidentiality;
4. he knew from reading investigation reports which had been requisitioned by him, usually on the instructions of his insurance-company principals, that investigators, including Centurion Investigation Ltd., had obtained medical information from hospitals and physicians' offices without the authority of their patients.

Mr. Miller added that he accepted the common practice of obtaining confidential medical information without authorization as proper when it was carried on. However, he agreed that, on reflection, the practice was improper and could not be justified.

William K. Miller Insurance Adjusters Inc. was incorporated on August 25, 1977, with the primary object of carrying on the business of an insurance adjusting firm. In early August, 1977, Mr. Miller had a meeting with John McGarry. An oral agreement was made by them which provided, in part, that Mr. McGarry would advance \$35,000.00 to the corporation as consideration for the issuance to his family, of 50 per cent of the shares of the corporation. The remaining 50 per cent of the shares were to be controlled by Mr. Miller and his family. Mr. Miller understood

that John McGarry preferred that the McGarry interest in the corporation not be disclosed to anyone.

By a written shareholders' agreement, made as of September 16, 1977, between Mr. Miller, Daniel McGarry and John McGarry, each agreed to the following provisions:

- (a) that the common shares of the corporation were to be held in these proportions: 10 by Mr. Miller and 5 each by John McGarry and Daniel McGarry;
- (b) Mr. Miller would devote his full time to the affairs of the company and receive a specified salary;
- (c) Mr. Miller's employment by the company was terminable, without cause, on one month's written notice, given by either Daniel McGarry or John McGarry;
- (d) Daniel McGarry or John McGarry had the right, in their sole discretion, to increase the number of the directors of the corporation and to designate their appointment;
- (e) Mr. Miller would not, for a period of one year from the date of the termination of his employment with the company, within the Province of Ontario, directly or indirectly, carry on the business of an insurance adjuster;
- (f) if Mr. Miller ceased to be an employee of the corporation, John McGarry and Daniel McGarry would be entitled to purchase all of the shares owned by Mr. Miller and his wife for either the sum of \$1.00 or the book value of the shares, whichever was the greater price.

This agreement was prepared by the solicitors who generally acted for the McGarry family. In the drafting and execution of this agreement, however, these solicitors acted for both the McGarry family and Mr. Miller and his family. To say that the agreement was improvident from Mr. Miller's viewpoint is an

understatement. Mr. Miller had all of the expertise in the adjusting field, and, at the whim of John McGarry or Daniel McGarry, his involvement with the corporation could be terminated on one month's notice, and he would not have the right to practice his profession for one year after the termination of his employment. The purchase of his shares would not likely be at a price advantageous to him or sufficient to compensate him for what he could be giving up. I have gone into the business relationship in detail because I believe that it is important if one is to understand Mr. Miller's conduct.

The company, as I have indicated, was incorporated on August 25, 1977, and it required a licence to permit it to carry on business as an insurance adjusting firm. An application was completed by Mr. Miller on behalf of the corporation, stating that Mr. Miller was the sole shareholder of the corporation. Mr. Miller gave an affidavit on September 8, 1977, swearing to the truth of all the facts set out in the application. Mr. Miller held the legal title in the one issued common share at the time the company was incorporated, but he admitted that the McGarry family held the beneficial interest in one-half of that issued share. Clearly, therefore, the affidavit was false because Mr. Miller was not, either in fact or in law, the sole shareholder of the corporation.

Before Mr. Miller was called upon to give evidence, and in the course of preparing for the hearing, Mr. Strosberg directed certain questions to him through his counsel. Later, Mr. Miller admitted that he had understood that Mr. Strosberg was interested in determining whether Centurion Investigation Ltd. or any member of the McGarry family, had any interest in his business. Despite this understanding, Mr. Miller answered the questions posed by Mr. Strosberg in such a way as to lead one to infer that neither Centurion Investigation Ltd. nor the McGarry family had any interest in the corporation or his business. Only when he was required to attend the hearing and produce the corporation's books, did Mr. Miller admit that the McGarry family did indeed have an interest in the corporation.

Mr. Miller is a man of honesty, integrity and reputation in the community. Why, then, did he swear a false affidavit and answer questions put to him in the investigative stages of our inquiry falsely? Mr. Miller failed to make full disclosure in his affidavit, I believe, probably because he was attempting to protect his economic interests. He was, in reality, by the terms of the shareholders' agreement, at the mercy of the McGarry brothers. The actual control of the corporation, by virtue of this agreement, was vested in John and Daniel McGarry. They were in a position, at their whim, and on one month's

notice, to dismiss Mr. Miller and to purchase his interest in the corporation at a price determined by a formula that did not necessarily reflect the true value of the corporation. Mr. Miller, in his own mind, unfortunately, must have considered himself to be the subject of financial duress. Mr. Miller testified, and I accept his evidence, that he was frightened. He said his fear was of this inquiry. I do not think that was quite accurate. I believe that he was frightened of the harm to his reputation, if it became public knowledge that he was associated with the McGarry brothers, whose conduct had already been called into question by the evidence given at our hearings. He also testified, and again I accept his statement, that, at the time the shareholders' agreement was entered into with the McGarry family, he made clear to John McGarry and Daniel McGarry, that he would not, in his capacity as an adjuster, be able to favour Centurion Investigation Ltd. with investigation work. I have no doubt that Mr. Miller honestly believed that statement when he made it. However, Mr. Miller was vulnerable in the hands of the McGarry brothers. He had a large volume of insurance work and was in a position to recommend to various insurance companies that investigations be undertaken. He was a man of such experience and respect in the insurance business community that his business volume would have increased quickly and the new corporation would have been economically successful in the near future. Once that took place, because of the shareholders' agreement, the fruits of his labour were capable of being taken over by persons who were less than scrupulous in their business methods. He could have found himself in the position of either improperly favouring Centurion Investigation Ltd. with investigation work, or being expelled from the adjusting business. I believe that this unfortunate incident illustrates the conflict of interest that may well develop if private investigators are permitted to invest in, or control, insurance adjusting firms.

Recommendation:

3. *That no corporation or individual licensed under The Private Investigators and Security Guards Act be permitted to own an interest of any kind in an insurance adjusting firm or to carry on business as an insurance adjuster.*

The incident which I have just described was one of extreme difficulty for me. I firmly believe, as I have said, that Mr. Miller is a man of honesty and integrity. I am sure that he found himself in a situation from which he thought that he could not extricate himself by telling the truth immediately.

Mr. Miller was mortified by the position in which he found himself and was ashamed of his actions. His evidence was full and frank in that respect. Elsewhere in this report I have expressed my view of the wisdom of prosecuting those persons and corporations who have acted improperly and even illegally. It is right that I should run the risk of repetition with relation to that issue as it relates to Mr. Miller's behaviour. Although there is no doubt that Mr. Miller has acted improperly, I recommend that no criminal prosecution be undertaken against him. It would serve no useful purpose.

CHAPTER 6

Quest Investigation Ltd.

After he left Centurion Investigation Ltd. in March, 1976, Kieran Patrick McCarthy applied for, and obtained, a licence to operate his own private investigation agency. By the end of April, 1976, Quest Investigation Ltd., Mr. McCarthy's agency, was in full operation. Mr. McCarthy's background and experience in the field of private investigation has been dealt with in my discussion of Centurion Investigation Ltd. and need not be repeated. It is enough to say that, by April of 1976, Mr. McCarthy was fully aware of the use to which improperly obtained medical information could be put, and the price it could command in the market place. In this connection, I have already pointed out that Mr. McCarthy, and Daniel McGarry of Centurion Investigation Ltd. had made a deliberate business decision, in which the weighing of the competing interests involved played no part, to embark on the implementation of a carefully organized system of obtaining health information without patient authorization. During the course of this inquiry, Mr. McCarthy co-operated fully with our investigators and gave them full access to his files. As a result of the investigation, approximately fifty files were obtained from Mr. McCarthy and placed in evidence at our hearings.

To illustrate the kind of health information obtained for its clients by Quest Investigation Ltd. I set out the following extracts from three investigation reports signed by Mr. McCarthy:

File No. 1010

Medical Information Developed:

Mississauga General Hospital

1. X-ray:

Skull - no fracture or abnormality.

Cervical Spine - slight torticollis convex to the left, no fracture.

Chest - lungs clear, fracture at lateral angle right third rib, not displaced.

Right Humerus - comminuted fracture at anatomical and surgical neck of humerus with impact, greater tuberosity is also fractured. An oblique fracture of proximal shaft with lateral displacement of distal shaft and fracture of olecranon process.

Left Humerus - fracture of surgical neck of humerus with slight lateral angulation at fracture site.

Right and Left Clavicals - normal.

Abdomen - radiolucent lines in transverse process on the left side of L2 and L3. This may represent an undisplaced fracture.

Pelvis - fracture of inferior ramus of right pubis of fracture line extending into body of pubis. Radiolucent line in region of right asatabulum extending medially which may be a fracture of the asatubulum, it is not displaced.

All of the above x-rays were taken May 1, 1975.

X-ray: hyperostosis frontalis interna is noted otherwise negative; pinal calcification in the mid-line. X-ray taken November 5, 1975.

2. Medical Records:

Subject was admitted through the Emergency Department on May 1, 1975 by ambulance. She was drowsy, had pain in upper arms, responded to loud verbal commands, was confused and had no recollection of the accident. She was incoherent and obviously in a great deal of pain.

Subject denied any previous health problems when admitted, however, it was determined from another source that she was diabetic and possibly epileptic. Source also stated that the subject was an abuser of alcohol and took tranquilizers.

Physical examination revealed that the Subject was drowsy, in considerable pain -

head and neck, had a bruise on the left frontal area, the pupils of the eyes had an equal reaction to light and accommodation, ENT - no significant abnormality. Subject has good mechanical movement, no tenderness of cervical spine. Chest - trachea mid-line good air entry both lung cavities with no chest trauma. Pulse was 84 and regular, normal heartbeat with no murmur, peripheral pulse passable. Subject's abdomen was soft and tender in right upper quadrant, tenderness of outside pressure of pelvis, both upper arms, crepitus obviously related to fracture of right humerus. Lower extremities intact.

Admitting diagnosis as above with diabetes, alcoholism and possible epilepsy noted. Dr. S admitted.

Summary: fracture of left surgical neck of humerus right comminuted fracture of surgical neck and shaft fracture of humerus and olecranon process, other fractures right side of pelvis.

On May 7, 1975 an open reduction of the right humerus was performed and dissection of radial nerve with open reduction of right olecranon with insertion of screw and application of a hanging plaster was carried out.

On May 15, 1975 manipulation of the right humerus fracture was proceeded with and recovery was good to excellent, however, medical situation was unstable due to social and economic conditions. It was felt that the Subject was on the way to becoming a recluse.

Dr. J (Internist, Mississauga General Hospital)

At the time of admission, Subject was conscious but disoriented and it was impossible to obtain a previous history.

Shortly thereafter, anemia, diabetes, epilepsy and alcoholism were recorded and

shown as treated, however, there were no doctors on file for these treatments.

It was learned that in January of 1974, the Subject was involved in a car accident, fracturing a rib but was not admitted.

Subject had had dizzy spells and is known to take Valium.

Fundi normal, thyroid palpable, no lymphadenopathy, chest clear, blood pressure not obtainable due to pain, however, when taken one half-hour later it was 62 systolic, diastolic not available. One IV ringer and one bottle of blood administered and blood pressure was 90/70. Pulse was 90 and regular with no murmurs. Abrasions were noted to the right and left knees and feet but there was movement of all limbs. ECG does not show recent myocardial infarction. Haemoglobin was 6.8 and 4+ sugar in urine.

Subject was previously admitted to Mississauga General December 1 and 2, 1972 complaining of chest pains radiating to the left arm and shortness of breath. There was no nausea or sweating. Thought to be coronary eschemia, however, finally diagnosed as anxiety. It was noted that both the Subject's parents had died of heart attacks.

At that time the Subject stated she had been taking thyroid extract for several years and myocillin (250 mg.) for two years. Also she has been in Sunnybrook two years previous to 1972 with similar complaints. Subject is allergic to penicillin and aspirin. Physical revealed head, chest and neck normal, blood pressure was 200/85. Doctors of record were Dr. K and Dr. S.

On the Extendicare admission, it was determined that the attempt to pass a pinion to the shaft of the right humerus failed and a plaster hanging case was put on, later removed by Dr. R (Surgeon). Subject attended physiotherapy prior to admission to Extendicare. Anemia on an iron-deficiency

basis is also listed on the discharge forms along with the fractures.

[name of clinic] (Dr. H)

Subject's first visit was February 11, 1974 for x-rays of chest and right hip showing some cardiomag, c.t. ratio in supine position was 15/26.5 (exaggerated supine), no evidence of abnormality. Fracture to right seventh rib. Skull x-ray showed no significant abnormality, however, pituitary fossa not well defined. Doctor was made aware by a friend that the Subject behaved unusually and was considered to be an alcoholic as a result of her husband's death. Subject took 5 mg. Vivol QHS for insomnia. Last visit was May, 1974.

Dr. B aforementioned in report of Friday, April 30, 1976 is Dr. B, [address, telephone number].

Dr. B

All files relative to patients at Extendicare Nursing Home are on file in that facility and no information was available from his personal files.

Extendicare Nursing Home

Mrs. A, Nurses' Station on Subject's floor; the patient being an inmate, all files are active and therefore further detailed information is unobtainable without required authorization.

File No. 1027

May 27, 1976

Medical Information Developed:

Sunnybrook Medical Centre, X-Ray records:

File:

April 16, 1976 - through emergency - cervical spine, skull, pelvis, left femur and pinion - no evidence of bony injury.
Dr. O (radiologist), Dr. M (Emergency).

April 20, 1976 - through emergency - skull x-ray, unremarkable and unchanged from previous x-ray.

April 23, 1976 - through emergency - echo encephliogram normal.

April 27, 1976 - through admitting - brain scan normal. Dr. R and Dr. H.

Family physician is listed as Dr. B, [address and telephone number].

Dr. B:

This is not the family physician and has never seen the Subject. Apparently Dr. B was called by a friend of the Subject's at the time of the accident. The friend described the symptoms and Dr. B advised the friend to get the Subject to Sunnybrook Hospital immediately as there was no way to tell what was wrong and it could be serious.

Wellesley Hospital, Medical Records:

File: W71428.

May 13, 1976 - The Subject saw Dr. S in the Fracture Clinic. The Subject was unable to walk without staggering, had ataxia and lack of co-ordination more to the right than to the left when given various tests such as hand clapping, touching the nose, etc. There was weakness in the right side of the body but no definite neurological findings. Total body almost full hemianaesthesia (loss of the sense of touch down one side of the body) not in the mid-line but beginning 2" across the mid-line. Almost full range of movement but with pain. Leg raising pain at 90° due to a tilt of the pelvis. It was suggested that no stronger analgesic than Darvon be prescribed.

Weakness was completely subjective. Total body hemianaesthesia described as functional, not organic. Ataxia is organic but it

was not thought to be an organic lesion, rather more a chemical lesion. Examination of the cranial nerves were visualized fundi with no intracranial pathology.

Previous history indicates that the Subject was involved in a car accident in April of 1968 and was again under Dr. S's care. There was post traumatic anxiety regarding the accident. The main problem was on the left side and the Subject was unable to stand.

In May of 1968, the Subject was treated at Branson Hospital for a heart seizure.

Shortly after returning to work, the subject complained of low back pain and left leg was unreliable on the pedal. He experienced pain in left leg raising and pain almost to the hips both right and left. There was no sign of spondolysis however an x-ray in 1968 shows poor disc at levels L-5 and S-1.

A pentothal pain study was conducted between September 15 and October 16, 1968 where the subject was tested with a great number of drugs to treat the pain. One-quarter grain of morphine, normal saline and demoral all produced some relief. The variety of the drugs used suggests functional pain.

The Subject was also under the care of a Dr. W, Psychiatrist. The Subject described a large change in his spirits after five weeks in the hospital when he was extremely depressed and saw everything as "black". This was a reactive depression evoked by the accident. Although still suffering functional motor and sense defects, with the use of Seconal and Valium to sleep, the Subject was reported as improved.

BUREAU NOTE:

There is some indication that the Subject was treated for similar accident injuries to those of the present and 1968 as mentioned

in our report, in 1973, his Wellesley Hospital card bearing a reference.

File No. 1057

Medical Information Developed:

Dr. G, [address, telephone number]

Dr. G's office has been closed for several weeks and will not re-open until August 9, 1976.

Dr. H, [address, telephone number]

The Subject has been consulting this Doctor for some ten to twelve years however, most complaints are standard, such as dry skin, etc.

He did have an SMR and Rhinoplasty, also x-rays for mastoids which were normal.

The Doctor's office confirmed a considerable hearing loss but did not appear to have a great deal of information other than Dr. B's report dated October 9, 1974 which you have in your possession.

There is mention in the file of a possible hyper-extension injury in September of 1974 and it was suggested that he may have attended either Joseph O. Ruddy Hospital in Whitby or Oshawa General Hospital.

This office has no reports from Dr. G and it was thought that the subject may have consulted Dr. G independently. There was no indication of previous neck or back problems.

Joseph O. Ruddy Hospital, Whitby (668-6831).

This hospital has no record of the Subject.

Oshawa General Hospital, Oshawa (576-8711).

There is a record of x-rays taken September 3, 1974 and a supplementary report on file. The original report has been misplaced and it was necessary to have the x-rays re-read to complete the file.

The report on the x-rays is as follows:

"Tip of spine of C-7 exists as a separate element. Opposing surfaces are relatively smooth, soft tissue swelling is not clearly present in this area. The appearance is that of a (clay shoveller's) fracture but I cannot tell if it is new or old."

No other abnormalities are seen. NOTE: 4mm. fleck of metal density projecting in the soft tissue of the anterolateral aspect of the base of the neck. No clinical or other information provided.

The Doctors of record are Dr. Ha and H (radiologist).

Dr. V, [address], (not as reported)
[telephone number].

Dr. V's office has Dr. B's report of October 9, 1974.

Railway employees are required to undergo a medical each year at which time, hearing is also checked. Either Dr. V or an area medical officer performs this check-up. The Subject did not attend at Dr. V's but it was unknown where he went for his medical.

The Subject was checked by Dr. V in June of 1975:

hearing in the left ear normal, in the right ear CB 10/20, and WB 2 feet and the tuning fork: right ear normal and left ear 10/20. He has not made any improvement but still meets Company standards in my opinion.

The Doctor's office advised that most records on the Subject would be in Montreal.

Dr. K, [place of employment], Montreal, [telephone number].

The last report they have on the Subject is from Dr. V and is dated July 3, 1975 (as above). A decision was made on the strength of that report that although the Subject was very deaf in one ear, he would be able to carry on his employment in the capacity of Yardmaster as the hearing in his other ear was considered to be normal.

According to Dr. K, employees do not necessarily have to have a test for hearing every year, the frequency being dependent upon where the employee is working and whether or not there is an ongoing hearing problem. Dr. K does not expect to receive any further medical information on the Subject until 1977 when he is scheduled for a periodic.

When queried on the ratio of hearing loss for employees engaged in yard work, the Doctor said that this was sometimes the case, usually attributable to age rather than occupation and that in the Subject's case this was not applicable as the hearing loss was in one ear only.

Dr. K was aware that the Subject had been involved in a car accident but had no further information in that regard.

It would appear there may be no medical reports on the Subject's hearing for 1972 or 1973.

Each available medical records was checked for any indication of a progressive hearing disability but none such was evident.

Mr. McCarthy pointed out that there was an additional number of files in respect of which he had obtained medical information without obtaining instructions from his clients to

do so. In these cases the medical information was supplied by Mr. McCarthy solely because, as a result of his assessment of his clients' needs, he perceived a need for a certain type of information in order for the insurer to deal properly with the cases for which the information was obtained. No useful purpose would be served by identifying clients who fall into the category of those for whom health information was obtained gratuitously.

Shortly after commencing operations, Mr. McCarthy consulted the Centurion Investigation Ltd. employee who had pioneered the use of pretext telephone calls for medical information to offer her a job at Quest Investigation Ltd. Although not interested in leaving the employ of Centurion Investigation Ltd., she offered Mr. McCarthy the following tips on obtaining medical information by telephone:

1. stay away from physicians;
2. speak to a nurse, rather than the physician;
3. speak to a clerk, rather than the nurse; and
4. adopt an officious, demanding and authoritative manner when dealing with health care personnel.

In adapting this advice to his own practice, Mr. McCarthy hit upon the device of using unpronounceable names, when telephoning health care personnel. If he identified himself as "Sterandolovsky" or "Jarislav Dubrovnic", Mr. McCarthy reasoned, the nurse or clerk would be too embarrassed to ask for the proper spelling. Mr. McCarthy related that, as a matter of fact, "Sterandolovsky" was the name of an East European forwarding company and "Jarislav Dubrovnic" was the name of a ship. Mr. McCarthy pointed out that, during the course of a pretext call, he did not specifically identify himself as a physician, but merely told the listener that he required the information because he had been "consulted about" the patient or that he was "taking a look" at the patient. Accepting, as I do, the evidence that Mr. McCarthy never directly passed himself off as a physician, I, nevertheless, have no difficulty in concluding that he intended that the person to whom he spoke believe he was a physician, and that the deliberate omission on his part of the title "Doctor" did not mitigate his unjustifiable misrepresentation. Mr. McCarthy admitted that it was his intention to deceive and that his deception was, in most cases, successful. That being the case, whether he felt it necessary to actually refer to himself as "Dr. Sterandolovsky" or simply, by his manner and actions led the health-care worker to whom he spoke to believe that he was Dr. Sterandolovsky is of no moment. The result was the same. Mr. McCarthy intended to practise a deception and did so successfully with the result that information

to which he was not entitled was disclosed to him. As he himself succinctly put it, "I was preying on the sloppy security."

To the tried and true techniques of pretext calls which he was largely responsible for developing while he was at Centurion Investigation Ltd., Mr. McCarthy added a new procedure to the arsenal of weapons used to breach the walls of confidentiality. As discussed elsewhere, large stores of medical information are held by employers in the Province of Ontario for the purposes of workmen's compensation and group sickness and accident insurance. Where an employee has been injured, either at work or elsewhere, he or she may be entitled to certain benefits. In order to receive those benefits, which are usually administered through the personnel department of his or her employer, the employee is obliged to file proof of his injuries. In Mr. McCarthy's words:

In many circumstances the personnel department of that company is sympathetic to the investigator who is investigating an employee who is goofing off.

When approaching an employer, in an attempt to obtain medical information relating to an employee, Mr. McCarthy adopted one of two approaches. In the first, he identified himself as a private investigator who had been retained by an insurer to investigate the employee. In the second, he employed a pretext. The pretext, complicated by most standards, involved contacting the personnel department and advising someone there that he was considering entering into a business arrangement of some sort with the employee who was the subject of the investigation. Before entering into this arrangement, he continued, he wanted some information relating to the employee's financial background and job security. After asking questions relating to the continuity of the employee's income, Mr. McCarthy continued and asked whether the employee would continue to be paid should he become injured. According to his explanation, the personnel department employee would reply affirmatively, saying that the company sponsored a sickness and accident insurance plan for its employees:

...she would tell you that he has collected it on one occasion. You say "What was that related to?" and she would say "He had a back problem arising out of an automobile accident". You say, "Well, I am a little concerned about getting into an arrangement with a person who is possibly not fit." She would say, "Well, he's been treated and he

seems to be all right. He was treated by Dr. So-and-so."

In response to a question asking for some explanation for his brazen conduct in seeking to obtain medical information to which he was not entitled, particularly from health care institutions and practitioners, Mr. McCarthy gave two separate grounds of justification. I have already dealt with the first, that is, that he took it upon himself to balance the patient's right to privacy against his client's right to know and had concluded that the latter was more important than the former. In this connection two exchanges at the hearings are instructive:

MR. STROSBERG: ...In any event, you say that you perceived this as an ethical problem. Did you perceive it as an ethical, as your ethical problem or did you perceive it as the ethical problem of the physician?

MR. McCARTHY: It wasn't the physician's problem which was a problem. Our problem was that the medical profession has a code of ethics that prevents them from releasing information and we had to find a method of bypassing their ethics.

Q. You didn't consider that it was an ethical problem for you?

A. From the point of view of our ethics, our clients' right to know superseded the patients' right to privacy.

Q. Yes, but what I am suggesting, you are not suggesting that in the early stages you considered that you and the other investigators had any ethical problem yourself to deal with as to whether or not this was proper?

A. Yes, sir. I have answered that.

Q. Well, what have you answered? The answer is that you did think that you had an ethical problem in the first instance?

A. Yes, sir.

Q. Why did you think that you had an ethical problem?

A. It was a judgment decision as to what was right and what was wrong, sir.

Q. Whether it was right to make pretext calls to the hospitals or doctors' offices, or whether it was wrong?

A. No. Whether it was right as to whether our clients' right need to know superseded a patient's right to privacy.

Q. Was this the substance of the discussion that you had with the McGarrys?

A. Not in the same detail as we are having it now, sir. No.

Q. But was that the substance of the discussion?

A. The substance of it, yes.

Q. Did you put it to them on the basis of, as you put it here, that it was a question of in the first instance whether it was right or wrong to do this in balancing your clients' right to know against the right of confidentiality of the patient?

A. I, I have difficulty in answering that, sir.

MR. COMMISSIONER: If I may ask, I ask because I am not quite sure what I am to draw from what has been said, you were under the impression that the difficulty standing in the way of getting information for your client was a code of ethics on the part of the medical profession?

A. Correct, sir.

MR. COMMISSIONER: That prevented them from divulging this information?

A. Correct, sir.

MR. COMMISSIONER: So you had a belief that there was no legal impediment in the way of your doing so? You had to devise a technique which would deceive them into betraying the confidence which ethically they were obliged to keep?

A. The technique was already in existence, sir.

MR. COMMISSIONER: Well, to use that technique?

A. To continue to use it, yes.

MR. COMMISSIONER: Continue to use that technique. The decision that, as between the two competing interests of the right of your client to know and the...

A. Need to know, sir. The right to privacy.

MR. COMMISSIONER: The need, the need to know and the privacy of the patient--and I suppose we can also say the ethical requirement of the physician. You thought that the paramount interest, as far as you were concerned, was the client's need to know and that justified deceiving the physician in order to get around his obligation to maintain confidentiality?

A. Based on my perception of the type of patient we were dealing with and some of the types of physicians we were dealing with, the answer is yes, sir.

MR. COMMISSIONER: Yes, and that explains why you make a decision to continue to deceive the physicians into betraying their confidence, but it doesn't explain the decision to use deception on hospitals. A hospital is an entity that is not a member of the medical profession. What about the propriety of deceiving the hospital into giving you information? First of all, did you, were you under the impression that there was any legal impediment in the way of

a hospital giving you the information, because it is not bound by the code of ethics that members of the medical profession are bound by? What do you have to say about the hospital situation? Did you know that a hospital was by law not permitted to divulge that information?

A. No, sir. I did not.

MR. COMMISSIONER: And you learned that eventually with great surprise?

A. I learned it about two and a half weeks ago, sir.

MR. COMMISSIONER: With great surprise?

A. Yes, sir.

MR. COMMISSIONER: Well then, if you didn't think they were under a legal obligation to maintain confidentiality, what was the problem, what was the corresponding problem with relation to hospitals?

A. I perceived them to be all in the same, under the same ethic of the medical profession.

I repeat that I find Mr. McCarthy's position untenable. Even leaving aside Mr. McCarthy's denial of any knowledge of physicians' and hospitals' legal duties to keep information about their patients confidential, Mr. McCarthy's economic interest deprived him of the objectivity that is essential for the process of weighing the competing interests. The balancing of those interests has been accomplished in legislation, and in our society it is simply not acceptable for a contrary solution to be preferred by private interests. Except where modified by the Legislature, the insurer's right to know must yield to the patient's right to privacy.

Mr. McCarthy's second ground of justification is equally untenable. Days of testimony and pounds of documentary exhibits were placed in evidence at the hearings on this branch of Mr. McCarthy's case. It is not necessary to do more than summarize the evidence briefly. Some time in 1974, while Mr. McCarthy was still employed by Centurion Investigation Ltd., that company tendered on a contract to supply security guards to

the federal Government. As part of the contract, the security guards were to be required to submit to, and pass, an examination set by the federal department of supply and services. After examining the course material, Mr. McCarthy came to the conclusion that the subject matter of the course was neither relevant nor necessary. He therefore set about to develop his own course of instruction for security guards and private investigators. These materials formed the basis of a manual which Mr. McCarthy and Centurion Investigation Ltd. proposed to use in a school for private investigators and security guards, which the company eventually established. After being advised that a school of this type needed the approval of the Private and Vocational School Branch of the Ministry of Colleges and Universities, Centurion Investigation Ltd. engaged in discussions with that Ministry. Centurion Investigation Ltd. was asked to submit the proposed course materials, that is, the manual, to the Registrar of Private Investigators and Security Guards, Chief Inspector Lyle of the Ontario Provincial Police. His approval was a condition precedent to obtaining Ministry approval of the school. After a number of meetings between Chief Inspector Lyle and others at the Registration Branch and Mr. McCarthy, and certain modifications to the manual, it received the necessary approval, and Centurion Investigation Ltd.'s school for private investigators and security guards opened.

At our hearings, Mr. McCarthy took the position that the practice of obtaining medical information by pretext had been approved by the Ontario Provincial Police, and that he was, therefore, entitled to rely upon the approval of the government body directly responsible for licensing and regulating his profession. This approval, Mr. McCarthy stated, was not merely tacit, but express, and he pointed to his manual as proof of this assertion. The manual was divided into various chapters, each of which dealt with a separate subject of interest. In one of the chapters, entitled "Contact Investigation Procedure", was a discussion of the uses to which pretexts could be put during the course of an investigation. An excerpt from that chapter reads as follows:

The correct use of a pretext is a valuable asset to the good investigator. It can be used when its use does not violate any law and the investigator should in no way attempt to impersonate a police officer or the representative of any legal organized union or institution or any government department, or represent himself as the agent of any company that exists or take

unto himself a badge or insignia or pass himself off as a fireman or the fire marshall or a utility inspector or a public officer, etc., thus for all practical purposes when the investigator presents himself as representing an organization or a company, said organization or company should be fictitious, that is nonexistent...

In the chapter headed "Standard Fraudulent Insurance Claims Investigation", there is much discussion about the various sources of information which a private investigator should approach. Under the sub-heading, "Medical", the following passage is found:

Here the investigator should endeavour to obtain all information possible from hospitals, doctors, nurses, chiropractors, physiotherapists, and particularly from the claimant himself in respect of past and present illnesses and injuries.

Mr. McCarthy took the position that these chapters were in the manual when it was delivered to Chief Inspector Lyle, and were approved by the Registration Branch without comment. He considered himself entitled to rely upon that approval and to employ pretexts in order to obtain medical information.

In response to Mr. McCarthy's assertion that the manual had been examined and approved by the Registration Branch, the Ontario Provincial Police led evidence to the effect that the manual to which Mr. McCarthy had referred in his testimony was not the same manual as that submitted to the Registration Branch, that, in fact, the manual submitted was not as thick as the one placed in evidence. In my view, if Mr. McCarthy was correct and the manual produced at our hearings was identical with that submitted by him to the Registration Branch for approval, the approval could not possibly have the consequence Mr. McCarthy urged upon me. Quite apart from the fact that no approval given by the Registration Branch to unjustifiable conduct could justify the conduct, the matter must be put in perspective. Centurion Investigation Ltd. wanted to obtain the approval of a branch of the Ministry of Colleges and Universities for its proposed school. The Ministry was not prepared to approve the course of study without some indication that it was appropriate. In order to satisfy the Ministry on that score, the Registration Branch, at the time, an under-staffed, over-worked and over-extended unit of the Ontario Provincial Police, was asked to examine the manual and simply

advise the Ministry of its opinion. The excerpts from the manual to which I have referred are very small portions of a volume which is easily an inch and a half thick. The chapters from which they are extracted do not immediately follow each other in the manual. Mr. McCarthy has sought to isolate two brief passages from the manual, taking them separately and out of context. The action of the Registration Branch of the Ontario Provincial Police in approving of the teaching of the technique of pretexts was unexceptional. There are as many situations in which a pretext can lawfully, and perhaps justifiably, be used, as there are situations in which it is unlawful and unjustifiable.

Moreover, it is not every approach by an investigator to a health-care provider to obtain medical information that is improper. Indeed, so long as the investigator makes full and complete disclosure of the reason for his request, an authorization executed by the patient may not even be necessary for the request for information to be proper. But to place together two statements, one dealing with pretexts and the other with medical information, and to rely on the failure to object to those unconnected statements as an acknowledgement that the practice of obtaining medical information by the use of pretexts is proper, is to place an interpretation upon approval which was never intended and is unreasonable. The Registration Branch was not asked to approve a code of conduct for private investigators. It was asked to examine study materials for a proposed school for investigators in order to determine if the subject matter was appropriate. It was not requested to approve of the practice sought to be covered in the lecture material. It was asked generally to review the material so that the Ministry of Colleges and Universities could be satisfied that what was proposed to be a course of study for private investigators and security guards would be satisfactory and potentially of some practical use. Nothing more was sought and nothing more was provided. I am unable to give effect to Mr. McCarthy's claim that he used pretexts to obtain confidential health information in the belief that the use had been approved by the government agency responsible for regulating his conduct. In short, there is simply no justification for Mr. McCarthy's practice of using pretexts in the manner and for the purposes I have described.

Finally, it must be said that, beginning with his employment by Centurion Investigation Ltd. and continuing with the creation of Quest Investigation Ltd., Mr. McCarthy, bears a large part of the responsibility for initiating and developing a well organized system of obtaining confidential health information. That development was highly instrumental in bringing about an exacerbation of breaches of confidentiality because of

the influence on other private investigating agencies because of their perceived need to engage in similar practices in order to remain competitive.

CHAPTER 7

Equifax Services Ltd.

Introduction

Retail Credit Company of Canada Ltd. was incorporated by letters patent as a federal private company on August 24, 1967. Its American parent, Retail Credit Company, commenced operations in the United States in 1899. In 1976, Retail Credit Company of Canada Ltd. changed its name to Equifax Services Ltd., concurrently with its parent's change of name to Equifax Inc. This was a reflection of a variation in the nature of the company's main work which was, in an early period, credit reporting but had recently become chiefly information gathering. The head office of the American company is in Atlanta, Georgia.

Equifax Services Ltd. remains a wholly-owned subsidiary of Equifax Inc. Equifax Inc. is generally considered to be the "giant of the American investigation industry". In testimony before the Privacy Protection Study Commission in the United States, the Chairman of the Board of Equifax Inc. estimated that Equifax maintained files on 39 million individuals in that country. As currently organized, the Canadian company, Equifax Services Ltd., has existed for almost three years.

Scope of Ontario Operations

Equifax Services Ltd. is the largest private investigation firm operating in Ontario. It employs from 50 to 60 full-time investigators in its claims investigation division and another 100 to 150 in its underwriting investigation division. In total, approximately 300 persons work for the company in Ontario. It maintains offices in several Ontario centres. Because of the manner in which the Equifax Services Ltd. files which were placed in evidence came into the hands of the Commission investigators, the 199 files which were marked as exhibits do not accurately reflect a representative sampling of the type of investigation report prepared by its different offices. Most of these files were obtained from the Toronto office, although a few of them were prepared in the Windsor, London, Kitchener, Kingston, and Ottawa offices. It should be pointed out that the files which were placed in evidence

represent, roughly, only .02% of all investigative files maintained by Equifax Services Ltd. in Ontario. William R.F. McKay, manager of the Toronto Claims Office, estimated that, excluding newspaper clipping files, approximately 90,000 claims investigation files are maintained at the Toronto office. Douglas R. Stewart, vice-president of the company, placed the figure for the total number of investigation reports of all kinds, maintained in its various Ontario offices, at one million. He estimated that claims investigations generate three to four million dollars in annual revenue in Ontario.

Operating autonomy was, I was told, granted to Equifax Services Ltd. in January of 1977. At present, however, much of the day-to-day operation is under the scrutiny and control of Equifax Inc., or, as the Equifax witnesses referred to the parent, "Atlanta". Operating autonomy was not to become completely effective until a five year period had elapsed. All financial and accounting services are purchased from Atlanta. The president of Equifax Services Ltd., Norman Smith, stated in a letter that only "administrative" matters were still under the control of Atlanta, and that responsibility and supervision of the investigative process resided in the Canadian management.

Mr. Stewart attempted to draw a distinction between company policy and company guidelines with respect to permissible investigative techniques. The Equifax investigator's handbook, the "Manual", is and has always been produced in Atlanta. This manual was characterized as "procedure" and not "policy". Mr. Smith stated that the manual set out nothing more than procedural guidelines which were, of necessity, modified to satisfy local conditions in each of the 50 states and 10 provinces in which the Equifax companies conduct investigations. On the other hand, Mr. Stewart, as I have said, sought to create a distinction between "policy" and "guideline". Guidelines, he said, were established in an attempt to interpret corporate policies. I find it hard to reconcile these positions, put forward as they are by the president and vice-president of the company. If, as Mr. Smith says, corporate policy is made in Toronto, how can the interpretation of that policy, as set out in the manual "guidelines", be undertaken in Atlanta? I can only conclude that what has been urged upon me by Equifax management is a distinction without a difference. More important than whether the manual sets out guidelines or a code of practice is how the field investigators and their immediate supervisors interpreted the manual or applied its provisions in practice. Mr. McKay testified that all Ontario investigations were conducted in accordance with the Atlanta manual. Mr. Stewart, Mr. McKay's superior, testified that the manual was

general in nature and that local situations were handled through "field releases" rather than manual supplements.

Despite the assertion that control over and supervision of Ontario investigations were firmly in Ontario hands, it is of no little significance that when dealing with those matters more clearly germane to my mandate, namely, the unauthorized obtaining of medical information from health-care providers, Equifax Services Ltd.'s reliance upon Atlanta became quite apparent. While admitting that his investigators had breached the manual instructions by seeking and obtaining "privileged" medical information (a term of art which will be dealt with in detail later) without the benefit of the patient's authorization, Mr. McKay steadfastly refused to label this behaviour improper. His justification for this position, briefly stated, was that at no time did Atlanta ever admonish Equifax Services Ltd. for obtaining this type of information.

One of the services which Atlanta continues to provide to Equifax is the "Quality Control Review Programme". Samples of investigation reports from each Equifax office are forwarded to Atlanta. These reports are examined and graded according to a scheme which is supposed to measure the performance of the Equifax office in which they originated. Mr. McKay took the position that Atlanta must have known, by reading these investigation reports, that Equifax investigators were consistently exceeding company policy. If Atlanta did not choose to comment on this consistent and continual breach of the manual, then it must not have been improper to obtain the information in the first instance.

In view of this apparent supervisory control exercised by Atlanta over Ontario operations, I considered it not unreasonable to request that a responsible and knowledgeable officer of the parent company attend to give evidence with respect to the matters involved in my inquiry. I was, of course, unable to compel a senior officer of Equifax, Inc. to attend because my powers to compel the attendance of witnesses under The Public Inquiries Act, 1971, S.O. 1971, Vol. 2, chapter 49, do not extend beyond the borders of Ontario. I thought, though, that a company which carries on its business in Ontario, even through a wholly-owned subsidiary, would have an interest in cooperating with a duly appointed commission of inquiry which is charged with the obligation of making recommendations which could affect that company's ability to continue to carry on business in Ontario. I was wrong in believing that cooperation would be forthcoming, if only as a mark of respect for an official body in this Province. Despite numerous public requests for the assistance of an officer of the parent company, Equifax Inc.,

which must have learned of my request, took the position, as was its right, that no one from Atlanta would be produced to explain its attitude toward what might be thought to be deviation in Ontario from company policy.

Having been denied what I consider to be an important source of information and explanation, I have been compelled to rely upon secondary sources of information. My power to refer to and rely on the results of research in an inquiry conducted under The Public Inquiries Act, 1971, is not in doubt. Therefore, unable to receive the assistance I needed from Equifax Inc. directly, I have examined and considered American material relating to the operations of Equifax Inc. In particular, I have referred to and rely upon the Report of the Privacy Protection Study Commission, before whom various members of the management of Equifax Inc. gave evidence. Furthermore, I have examined the documents and records relating to In the Matter of Equifax Inc., a proceeding before the U.S. Federal Trade Commission, arising out of a multiple-count complaint laid against Equifax Inc. on February 21, 1974.

While I cannot understand the reasons for Equifax Inc.'s refusal to cooperate, I am entitled, I believe, to draw inferences from this course of conduct. The inference which I draw is adverse to Equifax Services Ltd., but not because there was an evidentiary onus cast upon it which, in the absence of the requested testimony, has not been displaced. Rather, I find it difficult to believe that a company which apparently intends to carry on business in Ontario, in an industry which the evidence shows has been sorely lacking in, and in dire need of, regulation of some sort, would keep from public scrutiny the evidence requested by a body established by the Government of the Province. At first blush, it appears that any hope of properly regulating conduct in the industry is illusory if the leader and giant of that industry is content to remain out of the reach of the Province's jurisdiction and, at the same time expects to continue to be permitted to carry on business in Ontario.

“Privileged” Medical Information

It is sometimes in order to attempt an interview of a physician even though an authorization is not available.... In these cases we may obtain only non-privileged information which is limited to the names of doctors and the dates of treatment.

(Field Investigator's Manual, page 31)

Equifax Services...procedures have always been to seek medical information only when we have a proper authorization from the individual...

(W.J. Browning, Equifax Inc. Vice-President, quoted in Rx Confidentially, Vol. 1, No. 4, page 5)

[Equifax Inc.] requests a finding that: "There are certain basic facts in medical records which are not privileged, i.e., the dates of confinement to a hospital, the name of the hospital, dates of treatment by a physician, the name of his physician and admitting diagnosis, which may be disclosed without authorization."

(In the Matter of Equifax Inc., initial decision of von Brand, J., dated November 11, 1977, at paragraph 249, footnote 78)

Our definition of non-privileged information includes dates of admission and discharge, the name of the doctor, other interested insurance companies if any, and often, depending on the situation, how much the bill is.

(W.R.F. McKay, manager, Equifax Services Ltd., Toronto Claims Office)

Q. What information was privileged?
A. Medical information that required authorization to obtain.
(Evidence of Gerald Jerome before the U.S. Federal Trade Commission, at page 9657)

This distinction which Equifax has drawn between privileged and non-privileged medical information is one which has no basis in any of the relevant legislation in Ontario. The Public Hospitals Act, R.S.O. 1970, chapter 378, and The Health Disciplines Act, 1974, S.O. 1974, chapter 47, draw no such distinction. Furthermore, it becomes abundantly clear by reading their investigation reports which were filed in evidence that no distinction was made by Equifax Services Ltd. or its investigators. But this was not the position asserted by that company's management. Both Mr. McKay and Mr. Stewart continued to refer to the privileged, non-privileged distinction, as set

out in the manual, as merely a "guideline" and not corporate policy. This guideline, they explained, was to be interpreted in light of local conditions, because the guideline was to be applicable in over 60 different jurisdictions. It would not be unreasonable to interpret that explanation as meaning that the company had access to legal advice with respect to the information it was entitled to seek in Ontario. This inference was reinforced by Mr. McKay's statement that whenever one of his investigators advised him that some source had refused to disclose information because of some statutory prohibition, he would pass the fact on to his superior, so that a legal opinion could be obtained.

The statement of supposed corporate practice loses much of its force when weighed against statements contained in some of their investigation reports, such as:

We were informed however that under no circumstances will information be given out on the patient without the written consent of the patient. Due to this fact, we have found in the past we can get around this by obtaining information from the Patients' Accounts Department.

and

We were unable to obtain any information due to this hospital policy of not divulging any information. This is a new ruling and we have not yet been able to obtain sources in this hospital to get around this problem.

It seems likely that at no time did Equifax Services Ltd. seek to determine the legality of its practice in Ontario of obtaining medical information without patient consent. While one might not expect a non-lawyer to be able to cite the title and section of the particular statute which prohibited disclosure, it would not be unreasonable to expect that he or she would know that there existed some statutory provision which prohibited the disclosure of the information in question. The absence of such knowledge on the part of Equifax Services Ltd.'s management represents, to my mind, a wanton and reckless disregard for the laws of Ontario, or, at the very least, a wilful blindness.

It is necessary, I think, to explore further the Equifax privileged, non-privileged distinction, if only to show to what extent reality was divorced from theory in the largest private investigation firm in Ontario. Mr. McKay, in his early

testimony, stated that although this distinction was only a "guideline" and not "policy", investigators were trained and ordered to seek only non-privileged medical information. Furthermore, if the investigator innocently came into possession of privileged medical information during the course of his conversation with his "source", he and his supervisor had to make the decision whether that privileged information was to be included in the report to the customer, or simply disregarded and discarded. It was only after it became clear that his statement was at odds with the documentary evidence that Mr. McKay retreated from this position and admitted that the company's investigators actively sought privileged medical information, with his knowledge and tacit approval.

One of the files placed in evidence contained the following written instructions to the field investigator:

Obtain as much confidential medical information as possible through Dr. M, Dr. E, Dr. B...when dealing with Dr. MacD, obtain as much information as possible with regards to [the claimant]...

I propose to cite an excerpt from another file which, I must confess, contained more medical information than that found in the average report of an investigator employed by Equifax Services Ltd. The preparation of this report became the subject of a complaint and investigation by the Registration Branch of the Ontario Provincial Police (which is charged with the responsibility of regulating the private investigation industry, under the provisions of The Private Investigators and Security Guards Act, R.S.O. 1970, chapter 362). It is fair to say that the substance of this report was brought to the attention of Equifax Services Ltd.'s management, and, as a result, there exists no possibility that management was unaware of the extent to which its investigators were disregarding the manual guidelines.

Handling next conducted through the Etobicoke General Hospital, 101 Humber College Blvd., Etobicoke. Through source known to investigator, limited information was obtained on subjects. [The child-claimant] did have x-rays at this hospital April 16, 1975, while an emergency-patient. Attended in Emergency by Doctor [], Mississauga. Date of birth confirmed March 7, 1961.

Concerning [the mother-claimant], we note that she had x-rays at this hospital May 5, 1974, they being skull, chest and humerus ordered by Doctor P, and his address. No x-rays concerning [the mother] noted on or after loss of April 16, 1975.

We made further checks through the Hospital for Sick Children, and the Queensway General Hospital, concerning x-rays if any on [the child] or [the mother], whether following or prior to loss of April 16, 1975 - negative results...

Office, Dr. W...both [the child] and [the mother] were initial office patients here April 18, 1975, following the accident... Neuro-surgeon, Dr. P, admitted [the child] to the Sick Children's Hospital for tests October 14, 1975. Her hospital stay was a duration of some two weeks. Both [the mother] and [the child] were attended by neurologist Doctor S at the Etobicoke General Hospital...[The child] was last seen in the office here November 2, 1977. That visit not related to the accident in any way. She was suffering from a cold/flu at the time. [The mother] is at the moment attending therapy sessions in Brampton as arranged recently by psychiatrist, Doctor C. Also confirmed fact that the child had test done at the Queensway General Hospital. Doctor W of course has received follow up letters from all the above named specialists concerned in the case. The last letter dated February 15, 1977, is from office of psychiatrist Doctor C. Doctor C's summary of her at that time is as indicated, the patient had up to that point been suffering from a dystrophic reaction which had occurred shortly after the accident and may have well formed a psychological block aggravating the problem since then. C mentioned that he had applied hypnosis to her but this proved unsuccessful. Further conversation with [the child] and [her mother], the patient seemed well motivated because of the obvious limitation she was suffering at the time. He described her as a quiet spoken nervous

young lady. She had very little grasp in her right hand with marked reduction sensation in the third, fourth and fifth digit from the base of the digit to the tip on all aspects. He indicated that she had marked reduced grasp and some atrophy in the dorsum of the hand. The patient at that time had complained of tenderness in the shoulder extending from the base of the neck into the superior aspect of the scapula and out through the shoulder. That area was tender to pressure and some reduction in muscle strength was noted.

[The mother], we confirmed, did have a laminectomy L4-5 performed by Orthopedic surgeon Doctor N at the Peel Memorial Hospital in December 1976. According to available information it appears that Doctor N orthopedically reassessed her in the office at that time. Doctor W has essentially attended [the mother] in the office here since that period until now for problems non-associated with any accident. She was last into the office November 2, 1977...for diet pills. According to source, the laminectomy performed by Doctor N was minor surgery. She seems to have made a normal, lasting and complete recovery. We did of course question concerning [the mother's] treatment at the Etobicoke General Hospital May 5, 1974, by Dr. P as noted. Source had recalled that [the mother] was indeed involved in a motor vehicle accident on or around that date causing whiplash type and back injury. Was unable to advise us one way or the other whether Doctor W had attended her subsequently in the office. It appears that her back injury sustained in the accident April 16, 1975, may well have been an aggravated condition brought on by this previous accident May 5, 1974.

We found no reference to the recent MVA involving [the child] nor indication Doctor W has attended her in the office since. Suggested we contact Doctor C in that regard. Was [this source's] opinion that Doctor C was to date still attending [the

child] as an office patient. She may have made mention to him of that most recent accident. A check concerning her health history revealed no prior accidents or injuries other than noted to [the mother].

The Physiotherapy Department, Humber Memorial Hospital - [The child] we confirmed did attend here for physiotherapy treatments between the period of May 5, 1975 - June 12, 1975 (total of 14 visits). Referring physician identified as Orthopedic surgeon, Doctor Z...Physiotherapy was regards to injury of the right wrist. We note on regards to [the child's] visit here May 14, 1975, it was noted that she was at that time receiving a treatment to her right shoulder for 15 minutes followed by resistive exercises. On her final visit June 12, 1975, under physiotherapist Mrs. D, we note the patient was given wax to manipulate within her right hand for fifteen minutes. There were no complaints at that time concerning right shoulder pain or discomfort. She received active exercises for the right upper limb of the arm as well as ball throwing and wrist gripping, wax and ball squeezing. The right wrist also received resistive exercises that day. It was noted as of June 12, 1975, the patient was to start occupational therapy and the physiotherapy was to be discontinued awaiting on the outcome of the occupational therapy treatment to follow. There was no further record of occupational or other type therapy following June 12, 1975, available. Source was unable to comment in this regard...

We might inform you of additional inquiries on an indirect basis through the Etobicoke General Hospital, evening, December 5, 1977.

As well as confirming that [the mother] was attended in emergency by Doctor P, May 5, 1974, it was determined this was most certainly for a motor vehicle accident occurring or around that date. She had sustained injury to one of her arms that day. The family physician both confirmed

and identified as Doctor W. No additional relevant facts.

Peel Memorial Hospital - [The mother], date of birth confirmed September 28, 1929, O.H.I.P. No. was admitted to the hospital through the emergency department November 17, 1976...

Admitted to hospital for an acute herniated lumbar disc. There was indication that [the mother] did undergo a laminectomy L4-5 while here. No additional fact obtained further in that regard. While an in-patient, had a myogram performed November 18, 1977. An x-ray involving a disc case injection was ordered by N, November 19, 1977, and that specialist ordered a discogram November 22, 1977. Unfortunately, results of those x-rays could not be obtained. No in/out patient care for [the child] located.

We did also handle through the physiotherapy department Peel Memorial Hospital at this time. Spoke with Mrs. C. While confirming the child is presently on a programme through this hospital as ordered by Doctor C, she declined to divulge any information without the benefit of a signed authorization.

We were next in conversation with Mrs. L, medical secretary, orthopedic surgeon, Doctor N...[The mother] did receive post op care in this office following discharge from the Peel Memorial Hospital. We confirmed Doctor N did perform a laminectomy L4-5. We confirmed admittance date as November 17, 1976. Would not advise us her discharge date. Moreover, her post op visits while available were not released. She is no longer a patient of Doctor N. Was discharged from care some time ago. Past this point, no additional assistance given us without the benefit of a signed authorization.

A comparison of a typical Equifax report with a Centurion Investigation Limited report shows that Equifax did not

consistently obtain the extensive medical information from hospitals and physicians' offices that Centurion investigators were able to obtain. Instead, Equifax Services Ltd. capitalized on its position as the major provider of information to the insurance industry. The Equifax operations in Ontario, with which I am concerned, can roughly be divided into two separate areas--underwriting investigations and claims investigations.

An underwriting investigation is undertaken at the request of an insurer to assist the insurer in deciding whether to issue a policy of insurance to an applicant, and if so, the extent of its risk. Because the applicant for insurance is desirous of having the risk insured, he will cooperate with the insurer and its investigators, and will be required to execute an authorization of the release of information if he or she wishes the insurer to consider his or her application. Any information collected by Equifax Services Ltd. for underwriting purposes will therefore have been with the express consent of the insured. Underwriting reports are retained by the company for a period of 13 months.

Claims investigations on behalf of insurers are undertaken by Equifax Services Ltd. for two separate and distinct purposes. First-party investigations are undertaken when an insured claims from his or her own insurer under a sickness and accident policy. In these circumstances, because the insured is claiming for benefits arising out of his or her contract of insurance with the insurer, he or she is again anxious to cooperate, and Equifax Services Ltd. will seek the relevant information armed with the insured's consent to the release of information.

The second type of claims investigation, the third-party investigation, differs from the other two in that there does not exist the spirit of cooperation between the claimant and the insurer. In the third-party claim situation, the insurer does not stand in a contractual relationship with the claimant and has no right to require the claimant's cooperation. Any information which the insurer requires may not be obtained with the claimant's agreement, and Equifax Services Ltd. will, therefore, not possess the authority of the claimant when collecting information for its insurer-client.

Claims investigation reports are retained by Equifax for a period of 10 years.

Underwriting files are maintained separately from the claims files in a different section of the company's offices. All reports are filed alphabetically by the name of the subject of the investigation. Prior to the issuance of a directive in

1974, all underwriting and claims reports were kept together. As a result of the statutory requirement under The Consumer Reporting Act, 1973, S.O. 1973, chapter 97, that the subject of an underwriting report be notified of the use of that report for any purpose, Equifax Services Ltd. decided to segregate its files, so that underwriting information would not be used in claims investigations thereby necessitating the notification of the subject.

Mr. McKay testified that standing orders were issued in his office that claims investigators were not to look at underwriting reports during the course of an investigation. However, the underwriting files also contain newspaper clippings and other information which the investigator is entitled to examine. As a result, the investigator who decides to check for newspaper clippings on his subject is expected to refrain from examining an underwriting report when and if he finds one in the file. When asked whether this was a reasonable expectation, Mr. McKay stated that he was confident that his investigators would abide by Equifax policy and would not examine reports they were not supposed to read.

The reasonableness of this expectation is seriously undermined by several considerations:

- 1) The evidence presented during our hearings leads to the irresistible conclusion that Equifax Services Ltd.'s investigators did not hesitate to contravene Equifax policies, and did so consistently, with the knowledge and approval of their supervisors;
- 2) Equifax Services Ltd.'s investigators conduct their investigations under severe time constraints, the effects of which are accentuated by the fact that the investigator's remuneration is, to the extent of his bonus entitlement, dependent upon his production of reports;
- 3) The underwriting reports contain much more medical information than the investigator could expect to uncover during the course of his investigation, compiled as they were, with the cooperation and written authority of the subject.

As the insurers consistently requested that Equifax Services Ltd.'s investigators examine the past medical history of the subject, it is not reasonable to expect that the investigator working under these constraints and incentives would not seek to take advantage of easily available information.

When a request for a third-party claim investigation is received by Equifax Services Ltd., the first step taken, even before the matter is assigned to an investigator, is a check of all claim reports relating to the subject of the present request. So, for example, if Equifax had carried out an investigation on John Smith in 1972, that report would be pulled out and made available to the investigator, if, in 1979, an insurer requested an investigation of John Smith. This procedure would be undertaken even if the 1972 report had been compiled as a result of a claim by John Smith against his own insurer, under a sickness and accident policy. Although Smith would have authorized the release of medical information to Equifax in 1972, he would, in all likelihood, be surprised to learn that that information was to be re-sold to an insurer, in 1979, against whom Smith was claiming damages, and to whom Smith had not and would not authorize the release of medical information.

A further refinement on this practice of selling information obtained with the benefit of an authorization to a third-party insurer was described by Herbert Brereton, an Equifax Services Ltd. investigator. If Equifax Services Ltd. was retained by a first-party insurer to investigate a claim made by one of its own insured arising out of a motor vehicle accident, the investigator would interview the claimant and obtain a written authorization of the release of his or her medical information. Furthermore, the investigator would attempt to obtain from the claimant the details of the accident, including the name of the other driver and his or her automobile insurer. Armed with the claimant's authorization, the investigator would then assemble as much information as possible, and report it to the sickness and accident insurer which had retained the company. Immediately afterwards, the investigator, in accordance with Equifax instructions, would contact the third-party insurer against whom the claimant might pursue his or her claim for damages, and suggest to them that Equifax Services Ltd. should be retained to do an investigation on the claimant. If retained, the Equifax report to the third-party insurer would then contain the same medical information which the investigator had been able to obtain with the benefit of the claimant's authorization.

The third and final insurance industry link which Equifax Services Ltd. sought to exploit was the medical information which an insurer is entitled to acquire from its own insured when that insured is injured in a motor vehicle accident. Under Schedule "E" to The Insurance Act, R.S.O. 1970, chapter 224, as amended by S.O. 1971, chapter 84, section 26, S.O. 1972, chapter 66, section 18, O. Reg. 161/78 and O. Reg. 416/78, a person injured in a motor vehicle accident in Ontario is entitled to

receive from his or her own insurer up to \$140 per week for every week that he or she is totally disabled and unable to work. These amounts are payable by the insurer regardless of whose actions caused the accident. In order to prove his or her entitlement to these "no-fault benefits", the insured may, statutorily, be required to produce physicians' certificates attesting to his or her injuries, treatment and prognosis. Although Equifax Services Ltd. is not retained by insurers to collect medical information relating to no-fault claims, it is readily seen that the insurer required to pay no-fault benefits today may be the insurer against whom a third-party claim is made tomorrow. The following example is illustrative:

John Smith, who is insured by the ABC Insurance Company, is involved in a motor vehicle accident with George Black, who is insured by the XYZ Insurance Company. Smith claims no-fault benefits from ABC and Black from XYZ Insurance Company. Smith sues Black for damages. XYZ Insurance Company, Black's insurer, then retains Equifax Services Ltd. to conduct a third-party claim investigation of Smith.

The evidence before me made it clear that in such a situation, the Equifax investigator would not hesitate to contact ABC Insurance Company for the purposes of obtaining the medical information which ABC Insurance Company had secured from Smith. Again, there is no doubt that Smith would be surprised to learn that the information which he had agreed to release to his own insurer was to be resold to the insurer against whom he was ultimately claiming damages.

The evidence was also clear that insurers, without exception, agreed to supply and did supply Equifax Services Ltd. with the medical information they had compiled on their own insured. The insurer is under no statutory obligation to keep this medical information confidential. Nor is there an express contractual obligation to keep the information confidential. The wholesale exchange of medical information among insurers, in a spirit of cooperation and collegiality, or for any other motive, offends the notion that an individual has some right of privacy. The relationship between insurer and insured has been characterized as one of uberrimae fidei, or of utmost fidelity. Notwithstanding the absence of an express statutory or contractual obligation of confidentiality, there must exist an obligation on the insurer to do no act which may be to its insured's detriment. The release of information, which it had a statutory right to obtain, to a party adverse in interest to its insured, is such an act. Moreover, if the obligations of confidentiality statutorily imposed upon hospitals and health-

care providers are to have any significance, as a means of safeguarding the individual's medical history, insurers cannot continue to exchange medical information with impunity. To allow this to continue would simply be to force investigators to seek medical information from insurers rather than hospitals--a situation which, as the Equifax experience shows, renders the concept of confidentiality illusory.

The extent to which, as a matter of practice, Equifax Services Ltd. investigators approached the claimant's own insurer for the medical information obtained in the course of paying no-fault benefits is most clearly exhibited in one particular investigation report placed in evidence during the hearings. The Royal Insurance Company of Canada, one of the largest insurers carrying on business in Ontario, retained Equifax Services Ltd. to carry out an investigation on an individual who had been injured in a motor vehicle accident with another individual who was insured by that company. What the Royal adjuster who retained Equifax did not know was that the subject of the investigation was also insured by the same insurer, through a different branch office in Toronto. An Equifax investigator duly contacted the branch office which insured the claimant, obtained the medical information which that branch had obtained during the course of paying the claimant his no-fault benefits, and sold the information to the other branch of the Royal Insurance Company of Canada!

Aside from the medical information obtained from physicians, hospitals, and insurers, Equifax investigators sought, usually successfully, information of the type with which I am concerned, from school board employees and school nurses, the Workmen's Compensation Board, the Unemployment Insurance Commission, OHIP, police forces, employers and various government and public agencies, including probation service officers, Immigration Department investigators, municipal social assistance departments, the Ministry of Community and Social Services and the Ministry of Transportation and Communication. In short, no storehouse of information was safe from Equifax Services Ltd. investigators. Equifax investigators freely admitted that if an individual refused to disclose the information sought, because of some obligation of confidentiality, whether imposed by statute or by a contract of employment, the matter did not rest. The investigators simply closed off the conversation, and contacted another individual employed by the same "source". If the medical records department clerks refused to disclose information, the investigator attempted to obtain it from the patient accounts department, or the emergency department, or the physiotherapy department, or the x-ray department.

Certain of the Equifax Services Ltd. investigators admitted having knowledge of the existence of certain statutory prohibitions against the release of medical information without authorization. A former employee of Retail Credit Company of Canada Ltd., who was with the company from 1967 to 1973, John Brian Duff, whose evidence, discussed in the section devoted to W.A. King Ltd. and CCR, was, in other respects, not entirely satisfactory, testified about certain practices carried on while he was associated with the company. I set out the following extract from the transcript of his examination by Mr. Strosberg:

Q. ...Now, while you were at Equifax, Retail Credit and CCR, were you aware that records kept by any government agency, for example, OHIP records, were documents which were to be treated confidentially by the persons who had custody of the documents?

A. The answer to that is yes and no. If I could explain that, we were aware that the particular people that we required information from had taken an oath of secrecy and it was given to us at one time and I believe it's the Official Secrets Act, but that may or may not be...

Q. I don't think that that's the Official Secrets Act.

A. Okay. Well, whatever. I'm not sure. This was, that was something that was brought to our attention at one time.

Q. Where at, sir?

A. At Retail Credit Company, in those days. We, the claim directors at a claim directors conference in March of 1972, brought this point up to Mister Ed Trotechaud, who was the vice-president in charge of claims who was attending from Atlanta, and also other executives of the company who were there as to what our position was in obtaining this information. We were advised that most of the departments that we were obtaining this information from were already customers of Retail Credit Company for whatever reason it might be, like they had sold subrogation services, skip trace locate services to the

tax department, that is the federal income tax. Also the Unemployment Insurance and several other government agencies that I don't recall off hand, but just about any government agency that was in the information gathering business or even the collection of accounts for whatever reason it might be was a customer of Retail Credit Company.

Q. So how did that affect their obligation of secrecy?

A. They seemed to feel that since they were customers of Retail Credit Company, that Retail Credit Company has special privileges with these particular agencies in the government and we asked them to research that and they even had a lawyer from Atlanta to the Toronto office in the early seventies and that question was brought up. They seemed to feel that we were in no danger whatsoever. That if any problems were going to arise, the problems would be encountered by the people who gave us the information, not the people who received it.

That an investigator can continue to seek information which he knows to be forbidden is perhaps exemplified by the testimony of Mr. Brereton. Prior to becoming an Equifax investigator, Mr. Brereton had been employed as a claims examiner at OHIP. During his testimony, he conceded that when he first began his employment for OHIP, he was required to take the oath of secrecy, which is prescribed by The Public Service Act, R.S.O. 1970, chapter 386, for all provincial civil servants. Furthermore, Mr. Brereton recalled that he was advised, by his superiors, that employees of OHIP were also obliged, by The Health Insurance Act, 1972, S.O. 1972, chapter 91, to keep all information confidential. One might reasonably assume that Mr. Brereton, aware as he was of the proscriptions within both The Public Service Act and The Health Insurance Act, 1972, would, as an Equifax investigator, appreciate and respect the obligations of government employees generally, and OHIP employees particularly. That, however, was not the case. Although Mr. Brereton testified that he personally had never obtained information from OHIP, he did not hesitate to ask his fellow investigator, Robert Britnell, to contact his "confidential source" at OHIP in order to obtain the information which Mr. Brereton needed for his investigation. When asked why he

did not simply call OHIP directly, Mr. Brereton responded that he could not do so out of a concern for his self-respect because he knew that the information was required by law to be confidential!

When asked about the propriety of obtaining information which was required to be kept confidential, the Equifax Services Ltd. investigators maintained that what they did was constantly subject to scrutiny by their supervisors and by management. Since they had never been chastised for the information they obtained, and firm in the conviction that their employer carried on business in accordance with the law and ethical business standards, the Equifax investigators who were witnesses characterized their conduct as perfectly proper. Moving up the ladder of responsibility, it is fair to say that Mr. McKay, manager of the Toronto Claims Office, and therefore the individual to whom the investigators were ultimately responsible, saw no impropriety in his investigators' conduct.

Mr. McKay's position can be summarized thus:

- 1) If his investigators were improperly obtaining information, it would so appear in their reports. A sample of these reports were sent to Atlanta for audit. If Atlanta saw fit not to comment on the impropriety of obtaining confidential medical information, it could not be improper to seek to obtain it.
- 2) An individual may be under a statutory or contractual obligation to keep health information confidential, but it is that person's decision whether or not to disclose the information in breach of his or her obligations. Therefore, there is no impropriety in an Equifax investigator attempting to induce that individual to breach that obligation of confidentiality.
- 3) Equifax Services Ltd. carries on its business in accordance with the law and ethical business standards. Therefore, Equifax would not do anything that was not legal or not ethical.

Unfortunately, knowledge of the existence of the operating autonomy which, Mr. Stewart urged, was now firmly in Canadian hands has apparently not filtered down to the Equifax rank and file. At no time did Mr. McKay suggest that his superior, Mr. Stewart, had considered, let alone judged, the propriety of the Equifax practices. Yet, Mr. Stewart made it clear that he, and he alone, was responsible for evaluating and auditing the work of his managers. The reasons for Mr. Stewart's inability

to evaluate Mr. McKay's condonation and approval of the methods employed by his investigators are clear. It is also clear that Mr. McKay's reliance upon Atlanta for advice and direction made it important, if not imperative, that I be aided in my task by the cooperation of Equifax Inc. executives from Atlanta.

Mr. McKay's assertion that the obligation of confidentiality is that of the holder of the information and that Equifax investigators are entitled to obtain it, by whatever means, is, of course, entirely unacceptable. Earlier in his testimony, Mr. McKay stated that whenever an investigator advised him that a "source" had refused to disclose information because of some statutory prohibition, the matter was referred to counsel for an opinion. One would expect that, if that were the practice and that if the opinion was that there was in fact a legal prohibition, Equifax investigators would be instructed to refrain from obtaining that information. Mr. McKay cited no case in which, as a result of obtaining advice, Equifax investigators were prohibited from approaching a source of information in Ontario. That there was no such case seems a reasonable inference from the broad spectrum of sources mentioned in those Equifax reports which were placed in evidence. Furthermore, if the Equifax policy was correctly enunciated by Mr. McKay, that is, that "it cannot hurt to ask", it is difficult to see what need there would be for a legal opinion with respect to the obligation of confidentiality. One further comment on Mr. McKay's statement is in order. Assuming that there is no obligation to refrain from attempting to obtain confidential information, it must certainly be incumbent upon the investigator fully and frankly to advise his source of his identity and the purpose for which the information is being requested. Only if the holder of the information is fully apprised of all the circumstances could he or she be fairly charged with culpability in the decision to breach his or her obligation of confidentiality. As will be seen in the next section, the approaches used by Equifax Services Ltd. investigators were anything but full and frank. While perhaps not amounting to a positive misrepresentation, the introductions used by the investigators were calculated to mislead the holder of the information with respect to the real purpose for which that information was being sought.

Returning to the matter of how Equifax Services Ltd. characterized the conduct of its investigators, I propose now to move one more rung up the managerial ladder to Mr. Stewart who, as vice-president for the Central Region, was responsible for the company's operations in Ontario. It is to Mr. Stewart that Mr. McKay and all other managers in Ontario reported at the material times. Mr. Stewart explained that it was his responsibility to set policies and guidelines. It is reasonable to

expect, therefore, that it was to him that Mr. McKay would turn for guidance, advice and direction. In attempting to explain the distinction between Equifax policy and Equifax guidelines, Mr. Stewart said that "guidelines" interpret "policy". The manual sets out guidelines and is merely interpretive of the basic Equifax policy, that is, that it will carry on business in accordance with the law and ethical business practices.

The steps undertaken by Mr. Stewart to ensure that Equifax operations in Ontario were carried on in harmony with this most fundamental of Equifax policies can best be shown by a series of verbatim excerpts from his testimony:

Q. Were you aware before your company became involved with this inquiry that the boards of hospitals and their employees had an obligation to keep the records of their patients confidential when there was no authorization to release that information?

A. No, I did not.

Q. ...would you agree that in summation it would appear that you just weren't very much aware of any of these statutes that govern the obtaining of information?

A. That would be a fair summary.

Q. You don't accept what as a premise?

A. That we must examine all laws and all statutes. We do make a point of examining those that affect us directly.

Equifax Services Ltd. is a company which sells only one commodity and that commodity is information. I should have expected that the individual responsible for setting policy for that company would have taken all necessary steps to acquaint himself and his employees with all relevant legislation which might affect the business of obtaining and selling that one commodity. The laxity with which Equifax management undertook its task of ensuring that its investigators complied with enunciated policy is perhaps best exemplified by a situation to which the hearings of this Commission directly gave rise.

Approximately two to three weeks before our investigative hearings were scheduled to deal with Equifax Services Ltd.'s practices, and after much publicity had been given to the

evidence given at our hearings with respect to private investigators obtaining health information without the consent of the subjects affected, Mr. Stewart issued a new directive, prohibiting his investigators from seeking medical information anywhere in Ontario. These instructions were issued orally by Mr. Stewart to each of his Ontario managers:

Over a period of about a week or ten days, I talked to my branch managers in Ontario...I would have worded it differently with each manager, and I didn't write down exactly what I said, but the essence of what I said...was that from then forward [do not] obtain...medical information without authorization on claimants from doctors, hospitals or their employees... [emphasis added]

Mr. McKay received this order from his superior, Mr. Stewart. When asked for recollection of what Mr. Stewart had told him, Mr. McKay said:

We've been told to not contact any medical sources without an authorization until there are clear guidelines of what is permissible to ask these sources... [emphasis added]

Later, Mr. McKay was again asked for his recollection of this significant and important conversation:

Q. Can you remember what it is he told you?

A. As of right now, I want you to inform your people there will be no more contact with "medical sources"; it could have been "medical sources", or "doctors and hospitals"... That is the general message that I took back to my people. [emphasis added]

Mr. McKay then advised his unit supervisors of this directive, and they, in turn, advised their investigators.

Roy Crocker, an investigator employed by Equifax Services Ltd., testified that his recollection of the directive he received from his supervisor was as follows:

...he said to me "As of now no more contact with doctors and hospitals."

...he said "As of now, no more medical contact with doctors, hospitals." Perhaps "No more medical contacts." That was my connotation of it. No more medical contact.

My recollection of what was said, "No more contact with doctors, hospitals."

...other investigators have understood it to mean no more contact with medical sources of any kind.

Q. Well, what did you understand a medical source to mean?

A. Medical sources, no more contact with medical sources in my opinion means no more contact with medical sources per se. Doctors, hospitals, nurses in employment centres. Any kind of a medical source.

Mr. Stewart said that this directive was not intended to apply to information held by occupational health nurses. Mr. McKay thought it might. Mr. Crocker was certain it did.

Quite apart from its interest as a graphic example of the "broken telephone" game, the means by which Mr. Stewart issued this directive is instructive and descriptive of the laxity with which the company's operation was supervised in Ontario. Mr. Stewart could not have failed to know that the matter of this new directive, formulated as it was in response to our work and, I am sure it is fair to say, in anticipation of his eventual appearance before me, would be raised during the hearings and dealt with exhaustively. The subject-matter of the directive could not have been more germane to my terms of reference and concern. That a large corporation in which, the evidence indicates, the employees were not expected to abide by written guidelines and directives, thought it could discharge its corporate responsibility and avowed practice of carrying on business in accordance with the law and ethical business standards by issuing an oral directive which it must have known would be subject to the closest of public scrutiny simply does not make sense. The shortcomings of this course of action are patent. By the time the directive filtered its way down through the ranks to those employees to whom it was directed, its meaning had become garbled and ambiguous. Moreover, because the

directive had not been committed to paper, any request for clarification or direction by an investigator to his superior had to be dealt with purely as a matter of recollection and interpretation, a procedure which, of necessity, leads to varying and, obviously, inconsistent interpretations.

There is no need for public regulation of an industry in which each entity within it is capable of, and has shown a continuous and consistent practice of, responsible self-regulation. Equifax Services Ltd., the largest private investigation firm in Ontario and considered by the most to be the industry's leader, has plainly shown itself to be incapable of responsible self-regulation.

Methods

Hi, I'm John Smith from Equifax. I'm completing a claim for Ralph Jones.

I'm processing a claim by Ralph Jones.

I'm doing a business reference on Ralph Jones.

If the claimant or source asks the reason for the inquiry, you are to advise him that you are not permitted to divulge the purpose or source of this request. Proceed with the interview if you are able to satisfy subject in this matter...

(Field Investigators Manual, page 4)

All Equifax witnesses who testified, and the manual which was placed in evidence, clearly stated that an Equifax investigator was not to engage in pretexts or affirmative misrepresentations when seeking information. The only authorized approach to be used during third-party investigation, I was repeatedly told, was the "indirect approach", examples of which I have set out immediately above. Pretexts were forbidden because the source would be tricked or deceived into disclosing the requested information. This, however, had not always been the case. Until 1966, Retail Credit investigators (as they then were) were instructed to employ "suitable pretexts".

Over a period of many years, our instructions provided that in the handling of claim investigations on third-party claims, we would use a suitable pretext, but the instructions did not go beyond that. So,

therefore, the representative was left on his own as to how he would proceed.

(Initial decision of von Brand, J.,
In Re Equifax, para. 168, quoting testimony of Mr. Trotochaud, an officer of Equifax, Inc.)

In the 1966 amendments to the claim reports manual, which Mr. Trotochaud drafted, the use of pretexts was replaced by the "indirect approach". The indirect approach, which is still used by Equifax investigators, at least to the extent that Equifax investigators comply with any of the "guidelines" contained in the manual, requires that the investigator identify himself and the name of his employer, and that at no time should the word "insurance" be mentioned.

The decision not to use the word "insurance" was made, I was told, because of the concern that, if the source were to be advised that the investigator's inquiries were in connection with a claim against an insurer, the source might give only information that would be favourable to the claimant, either by withholding information detrimental to the claimant, or by exaggerating the claimant's injuries. Sources would not be unbiased and would attempt to help the claimant's cause. Equifax Services Ltd., neutral as it professes to be, is interested in obtaining factual information.

On any objective analysis, the distinction which Equifax Services Ltd. tried to make between "pretexts" and the "indirect approach" is semantic quibbling. The examples of the indirect approach given above are misleading explanations of the function of the investigator and, as such, are pretexts just as much as a misdescription of the investigator's identity would be from the point of view of the effect on the person addressed. With one exception, with which I shall deal later, Equifax investigators did not hold themselves out as physicians, law enforcement officers or health-care workers. But, the indirect approach used by the investigators represents the most sophisticated and subtle misrepresentation examined during our hearings.

The phrases, "processing a claim" or "completing a claim", do not accurately or fairly describe the investigator's activities. These expressions connote some type of administrative or bureaucratic paper shuffling. For the most part, health-care providers in Ontario are paid, not by the patient, but by an insurer. This insurer may be OHIP or it may be a private insurer, such as Blue Cross. Without distinction, however, is the requirement that the health-care provider complete and submit numerous forms in order to be paid. As a result,

physicians' employees, as well as hospital employees, are used to the huge paper flow necessitated by this administrative arrangement. Furthermore, the physician's secretary, for example, realizes that her employer will not be paid for a particular treatment or procedure unless and until the insurer is satisfied that the submitted claim is properly substantiated. When that secretary receives a telephone call from an individual who states that he is completing a claim, and asks for medical information or confirmation of certain facts, she may not even be certain whether the claim referred to is a claim possibly made by the patient, or the claim she may have submitted on behalf of her employer. The phrases "processing a claim" or "completing a claim" give the impression of a clerical contact for routine administrative purposes.

It may be said that the coined name, Equifax, conveys the idea of an official acronym more than an investigation firm. Indeed, Mr. McKay was asked how the name "Equifax" was derived, because it sounded so innocuous as to be meaningless to a hospital employee who was contacted by an investigator. After it was explained that "Equi-" referred to "equitable" and "-fax" referred to "facts", the questioner (who was not commission counsel but rather a hospital administrator), with an obvious feeling of confusion, made this remark,

...I still think it's a rather odd name.
Well, it might be great for a horse, but...

The extent to which the use of the indirect approach could and did give rise to confusion and misapprehension of the facts is best exemplified by the situation to which I referred earlier, in which a particular approach by an Equifax investigator gave rise to an investigation by the Ontario Provincial Police. Herbert Brereton telephoned the office of Dr. Ralph Wright in order to obtain medical information relating to two of Dr. Wright's patients. He spoke to Dr. Wright's wife who worked in his office. Mrs. Wright thought that Mr. Brereton said he was "Dr. Burton from Equifax Claims". Mrs. Wright testified that she assumed Mr. Brereton was an employee of OHIP who was attempting to verify the claims submitted for payment. Thinking that OHIP had a right to the information requested, Mrs. Wright continued to answer Mr. Brereton's questions and disclosed the extensive medical information which I have reproduced earlier. Although Mrs. Wright maintained that she was certain Mr. Brereton identified himself as a doctor, Mr. Brereton denied it. I accept Mrs. Wright's evidence and am satisfied that Mr. Brereton did identify himself to her as "Dr. Burton". Mrs. Wright thought that she was being asked for information needed to evaluate and pay the claims of her husband's patients,

and acting under that misapprehension, she was prepared to co-operate with the caller.

I have already mentioned the laxity with which Equifax management supervised the work of its investigators. Another example of this arose with respect to the "indirect approach". The Equifax investigators who were called upon to testify all indicated that the use and value of pretexts were well-known in the private investigation industry, but that Equifax rules allowed only the indirect approach when attempting to elicit information. Mr. McKay was asked what controls were in place to ensure that his investigators did not use pretexts in their attempts to obtain medical information. He explained that there exists a "Quality Control Review Programme", by which, on a random basis, the Equifax investigator is himself investigated. An investigation report prepared by a given investigator is chosen, and a member of the Quality Control team then re-contacts all the sources listed in the original report. As a result, Mr. McKay explained, the re-investigator would quickly learn if the investigator had not properly identified himself as an Equifax investigator.

The weakness in this procedure is obvious. The form used by the individual carrying out the re-investigation as part of the Quality Control Review Programme specifically states "DO NOT CONTACT MEDICAL SOURCES". As a result, the re-investigator does not communicate with the doctors' offices or hospitals listed as sources by the investigator, and cannot, therefore, determine if a pretext was employed. The other means by which Equifax would learn that an investigator had used a pretext, suggested Mr. McKay, was the receipt of a complaint by Equifax, the insurer, the Superintendent of Insurance or the Registrar of Private Investigators and Security Guards. But the source would have no cause to complain unless the pretext was unsuccessful. The successful pretext defies detection and, that is clearly its intended purpose.

I shall return to the indirect approach after a digression to discuss the one documented incident in which an Equifax investigator employed a pretext in order to obtain medical information. On March 25, 1977, Equifax Services Ltd. investigator Roy Crocker telephoned Dr. A. Katz, a Toronto physician, and identified himself as Dr. J.K. Reid. Dr. Katz quite properly refused to disclose any information to "Dr. Reid", and advised his patient of this surreptitious attempt. A complaint was made to the Superintendent of Insurance.

Mr. Crocker testified before me that he had become frustrated during the course of that particular investigation, and

thought that misrepresenting himself to Dr. Katz was the only means by which he could obtain the medical information he considered necessary to the investigation. During his 15 years as an Equifax investigator, he said, this was the only occasion upon which he had represented himself as a physician. It will be remembered that, during the early portion of Mr. Crocker's career, the Equifax manual exhorted the investigator to use "suitable pretexts". I find it incredible that on the only occasion upon which Mr. Crocker chose to represent himself as a doctor, he was caught. He only did so on this occasion, he wanted me to believe, because his investigative efforts had been frustrated. I should have thought that frustration is a constant factor in the business of private investigation. In his 15 years as an investigator, Mr. Crocker must surely have been frustrated on other occasions.

In the absence of other evidence, I would not have been prepared to conclude that Mr. Crocker was less than candid when he testified that he had impersonated a physician only once in 15 years. But other, independent evidence was offered by Mrs. Beryl Feeney, an accounts receivable clerk at the York-Finch General Hospital. Mrs. Feeney testified that on numerous occasions in the past, both Mr. Crocker and Mr. Brereton had called her and requested confirmation of certain facts relating to the hospitalization of particular patients. Approximately three years ago, Mr. Crocker stopped calling Mrs. Feeney, because she refused to give him the information he requested. Although Mrs. Feeney was prepared to confirm dates of hospitalization, she advised Mr. Crocker that, in order to obtain any further information, he would have to present a valid authorization signed by the patient.

Mrs. Feeney testified that, on three separate occasions, Mr. Crocker called her, and claimed to be a doctor in need of information. She could not recall the name he used, but was able to identify his voice with certainty. As soon as she recognized his voice, Mrs. Feeney simply transferred the call to the medical records department. At some later point, the medical records department staff complained to the assistant administrator about this man pretending to be a physician because, "apparently, he was sort of bugging them in Medical Records". The hospital attempted to identify the caller, but was unsuccessful because Mrs. Feeney could remember only his surname, Crocker, and not the name of his employer. On those occasions when Mr. Crocker, posing as a physician, spoke to Mrs. Feeney, Mrs. Feeney believed that he had not asked for her by name, but that she had simply answered the telephone. As a result, it is reasonable to assume that from time to time, one or more of her co-workers, not being familiar with Mr. Crocker or aware of his intentions,

complied with his requests for information. Although in no way conclusive or dispositive of the issue, before she gave her evidence, Mrs. Feeney was able to identify Mr. Crocker's voice on the tape recording produced by the recording equipment used in our hearing room.

The evidence does not justify a conclusion that, apart from Messrs. Brereton and Crocker, Equifax investigators misrepresented themselves as physicians in an attempt to obtain medical information. Mr. Crocker admitted to so misrepresenting himself only once. I conclude, however, that that kind of impersonation was resorted to by Mr. Crocker on other, probably many, occasions in the past, although he was caught only once. This is not surprising, for the properly executed pretext, as I have said before, raises no suspicion.

I return, briefly, to the discussion of the indirect approach--an approach which Equifax management considers accurately and fairly discloses its purpose in seeking the information. I repeat that it was the Equifax position that the indirect approach was necessary in order to obtain truthful and unbiased information.

Insurance companies have learned through experience that, in a third-party claim situation where the company is dealing with an adversary claimant (as opposed to its own insured), it is not possible to develop the information needed if the interviewer discloses that insurance is involved. If the person is "speculating" on the claim, has something to cover up, or in plain and simple terms is a thief, he will not provide the honest response which is necessary to evaluate his claim fairly, if he knows the interview is in connection with that claim. Thus, the insurance company which ordered the claim report based on the indirect approach has a legitimate interest...in having the report completed through an indirect interview...

(In re Equifax, Appeal brief submitted by Respondent, Equifax Inc. on January 30, 1978, at page 25)

In today's society, there could hardly be any investigative technique more in the public interest than the indirect approach,

and there is no excuse for banning it.
(Ibid., at page 24)

I have difficulty reconciling Equifax's professed intention, that is, to obtain unbiased and uncoloured facts through the medium of the indirect approach, with the testimony of several "medical sources" who appeared before me. For example, Nour Issa, the receptionist in the medical records department of North York Branson Hospital, thought she was helping the patient by releasing the requested information to Equifax investigators. Mrs. Issa was convinced that the information was needed in order to speed up payments to the patient. In fact, Mrs. Issa operated under the misapprehension that Equifax Services Ltd. was itself an insurance company.

...I thought they [were] an insurance company. To me, they are working for the benefit of the patient.

I thought they [were] just collecting money for the patient or, you know, they want information just for the benefit of the patient.

As a result, while adopting the indirect approach in order to avoid the possibility that sources would respond with information intended to aid the patient, the indirect approach had that very effect. Sources cooperated because by so doing, it was thought the patient would benefit.

If, as Mr. McKay strenuously urged, it is Equifax Services Ltd.'s right to ask "all the questions of all the sources" because it is incumbent upon the holder of medical information to decide whether to breach an obligation of confidentiality by disclosing it, then, as I have already pointed out, it is incumbent upon the Equifax investigator to ensure that, before making that conscious decision, the information holder is made aware of all the facts relating to that request. In particular, the source cannot be led to believe that the investigator is acting in the patient's interest, or in an interest congruent with that of the patient. The use of the indirect approach does not provide the source with those facts. It is neither designed nor intended to do so. I am, at the moment, not concerned with the question whether there is any impropriety in the use of the indirect approach when dealing with persons who are under no obligation to maintain the confidentiality of medical information. I must say, however, that the fact that Equifax Services Ltd. took no steps to ascertain who in Ontario was under such an obligation makes such a distinction harder to draw.

As I have already said, I find it hard to accept the view that "processing a claim" or "completing a claim" could be thought fairly and accurately to characterize Equifax Services Ltd.'s actions in undertaking an investigation. It is equally incredible that its investigators and their supervisors genuinely believe their stated position that Equifax Services Ltd. stands neutral between third-party insurer and claimant. Despite their repeated and often vociferous protestations that all Equifax investigators were hired to do was to uncover the truth and report it in an honest manner to their clients, Equifax Services Ltd. is not neutral, in any sense of the word.

What, then, need be said of the indirect approach, "I'm doing a business reference on Ralph Jones?" This approach does not disclose to the source the fact that Ralph Jones has made a claim. But, asserted the company's witnesses, Equifax Services Ltd., in undertaking a third-party claim investigation, is engaged in completing a business reference. Mr. McKay's explanation was as follows:

Q. ...if you go and say, "I'm doing a business reference", that's not a pretext?

A. No.

Q. ...if you go and say, "I'm doing a shopping survey", that's not a pretext?

A. That would be if you weren't doing a shopping survey.

Q. ...if you're not doing a business reference, wouldn't that be a pretext too?

A. If you weren't doing a business reference, yes...We consider making a claim report as a...business reference...If I come to your door and introduce myself, and who I'm with, and say I wanted to speak to you on a business matter, or...regarding a business transaction and you agreed to talk to me, we don't consider that a pretext.

Mr. Crocker drew no distinction between an investigation and a business reference.

Q. Is there a difference between a pretext and an indirect approach?

A. An indirect approach, as far as I am concerned,...is if and when I interview a claimant I identify myself as Crocker and [say] I am doing a business report.

Q. That's an indirect approach?...But is it true that you are doing a business report?

A. I would say that it is...

Q. Isn't it an investigative report?

A. ...are they not the same?...It's used for business purposes, I would assume.

Finally, Mr. Stewart was asked for his views on the accuracy of the introduction, "I'm doing a business reference on Ralph Jones":

Q. Is it your opinion that [this phrase] is a fair description of the activities that the Equifax investigators are undertaking?

A. Yes, it is.

Q. ...is it not simply a sophisticated type of pretext?

A. I don't accept [that] at all.

Q. How can an investigation be a business reference?

A. It's a business transaction.

Q. Isn't an investigation something different from completing a reference?

A. You could argue that it is. You could argue that it isn't, too. That's interpretation.

To view "I'm doing a business reference on Ralph Jones" in its best light, it is ambiguous and open, as Mr. Stewart admits, to "interpretation". Nothing in the evidence compels me to conclude that the darkness surrounding this introduction was ever made lighter. Equifax Services Ltd. intended that the indirect approach would be open to "interpretation" by the source. No attempt was to be made to dispel any misconceptions or

misapprehensions. Equifax Services Ltd. was content to allow individuals who were under an obligation to keep medical information confidential to believe whatever they wished, so long as holding that belief prompted the individual to disclose the information.

Conclusion

The most fundamental corporate policy of Equifax Services Ltd., I was told, was that Equifax should carry on its business in accordance with the laws of Ontario and ethical business practices. That it did not carry on its business of obtaining medical information in a way that reflected respect for the relevant laws is clear. What I find more important, however, is that, despite its vice-president's assertion that Equifax Services Ltd. examines those laws that affect its business directly, it is clear, from Mr. Stewart's testimony, that Equifax Services Ltd., in its many years of doing business in Ontario, never saw fit to consider the applicability of statutory confidentiality provisions to its operations. Equifax Services Ltd. sells a product, information. Nothing could affect the sale of that product more directly than duly enacted legislation which prohibits the disclosure of information, except in certain circumstances. As I have said, a more charitable view of the company's activities might have been taken, had the company actually sought an opinion as to the propriety of its operations, even if that opinion turned out to be wrong in law. Had Mr. McKay been correct when he stated that whenever an investigator was advised by a source that the information could not be disclosed because of some statutory prohibition, a legal opinion was obtained, then Equifax Services Ltd. would not now be in the position it is. It is unacceptable for the leader in the industry to exhibit such a wanton and reckless disregard for the laws of the jurisdiction in which it operates.

I cannot leave the discussion of Equifax without one final word about its relationship with its American parent. Those aspects of the Equifax operation in Ontario with which I am concerned, that is, the so-called privileged, non-privileged medical information dichotomy and the indirect approach were both formulated and instituted by Equifax Inc., the American company. The manual, to which I have made repeated reference, was written in Atlanta. The manager of the largest Equifax office in Ontario viewed as the final arbiter of the propriety of his investigators' behaviour, Atlanta. Control of Ontario operations, I was told, is not in Atlanta. Yet, I have no evidence upon which I can weigh this statement. I can say that

if control of the Ontario operation is in Ontario alone, then, in fact, there is no control over the Ontario operation.

I did not want to be compelled to consider the Equifax activities without the light which I was, and continue to be, certain could be shed by an Equifax Inc. executive. No one who appeared before me could tell me why a distinction ought to be drawn between privileged and non-privileged information. No one could tell me why the indirect approach was instituted in 1966. Indeed, no one told me that the use of pretexts was urged until 1966.

My intention is not to find fault or wrong-doing. I am concerned with making intelligent recommendations relating to the safeguarding of medical information. Repeatedly I asked for assistance in this onerous task from Equifax Inc. I was refused at every turn.

Recommendation:

4. *That The Private Investigators and Security Guards Act require that a majority of the issued and allotted voting shares of a corporation licensed under the Act be beneficially owned by persons ordinarily resident in Canada.*

Carl Franco and Franco Investigation Services

Since 1969, Carl Franco has carried on the business of a private investigator in Ontario as Franco Investigation Services. During 1978, he employed an average of approximately 10 persons, mostly part time. He had immigrated to Canada in 1969 from Israel where he had also been a private investigator. Mr. Franco admitted that at all material times he knew that physicians and hospital employees had an obligation to keep health information confidential. Despite this knowledge, like many others in the investigation and insurance industry, Mr. Franco accepted the practice of attempting to obtain confidential health information by pretext from physicians, their employees, and hospital employees. In 1973, Mr. Franco's clients began to demand that he obtain confidential health information. According to Mr. Franco, in each case in which his employees attempted to obtain confidential health information without the patient's consent, his clients expressly directed him to seek that kind of information. Because of his accent, Mr. Franco never made pretext calls himself but his employees did so with his express consent and he accepted responsibility for their actions.

In 1974, Mrs. Carol Presement, a licensed private investigator, began to work for Mr. Franco. From 1974, she made all his pretext calls. She called both hospitals and physicians' offices. When she called hospitals, she normally spoke to someone in the business office and asked whether the patient was still hospitalized and what the status of the OHIP claim was. She intended to leave the impression that she was entitled to receive the information she sought and that she was from another part of the same hospital or from OHIP, although she was careful never to make such a representation expressly. On occasion, she attempted to obtain medical information from the medical records department of various hospitals but she was usually unsuccessful. Sometimes she claimed to be a close member of the patient's family and to be calling from out of town to inquire about the patient's condition. As a result of a claim of that sort in the course of an investigation she was carrying out on behalf of Adamsons Limited, an insurance adjusting firm, she obtained the following information from a nurse at the Toronto General Hospital:

Confidential Medical Information

We conducted a confidential medical investigation and learned that the subject is coming along fairly well and will be in the hospital for another few weeks before being transferred to a convalescent hospital.

The subject sustained bilateral fractures, which in themselves were not bad fractures, however the area around the knee, where the fractures are located, is what is causing the complication.

According to our confidential medical information the subject was in casts for quite a while and is presently being reambulated and is not weight bearing yet. The subject's knees are quite stiff and the purpose of the present physiotherapy is to get the subject's knees to bend again.

We further learned that the subject's fractured wrist is quite healed.

While probing into the possibility of any permanent disability as a result of the accident we learned that in spite of the fact that at the present time it is too early to determine any fact pertaining to the subject's final recovery, her situation is gradually progressing and there is only an indication that the subject may remain with some permanent disability, however as mentioned above, it is too early to determine.

From time to time, Mrs. Presement called physicians' offices. On these occasions she said that she was calling for a patient to confirm the patient's next appointment. She would thus learn the date of the next appointment. Sometimes she claimed to be calling about the OHIP claim. Once the physician's employee began talking, Mrs. Presement was usually able to extract confidential health information. In her evidence she admitted that when she claimed to be calling about the OHIP claim it was implicit in what she said that she was calling from OHIP itself. From one call of that kind she was able to obtain the following information which she later reported to Commercial Union Assurance Company:

Medical Treatment

During our indirect investigation we learned that the subject attended at her family physician, Dr. S, after the accident and has seen him on two occasions since the accident, her last visit being September, 1976.

The subject is suffering from neck and back discomfort, however as we indirectly learned she has not worn a back brace or collar and to date has not attended for physiotherapy treatments.

The subject's next doctor's appointment is around the end of September 30, 1976 at which time the possibility of physiotherapy treatments may be discussed.

The following account of one Franco investigation is illustrative. On June 23, 1976, a motor vehicle, insured by Fireman's Fund Insurance Company of Canada, struck a child walking in a pedestrian crosswalk. Bryan Smyth, an employee of the insurance company, told Mr. Franco that the child had suffered a head injury, and had been treated at North York Branson Hospital and provided him with the OHIP number. He asked Mr. Franco to find out if the child had developed deafness as a result of the accident and whether he had any pre-existing difficulties with his hearing. Mrs. Presement made pretext calls which enabled her to obtain confidential health information. Mr. Franco's report of March 22, 1977, read, in part, as follows:

Confidential Medical Information

During our investigation we were confidentially able to confirm that the subject was admitted to the North York Branson Hospital on June 23, 1976, as a result of a motor vehicle accident and he was discharged on June 27, 1977.

Diagnosis

The subject's situation upon admission to the hospital was diagnosed as:

Fractured Skull

While confidentially probing into the subject's medical situation we were able to confirm that the subject has attended at

Dr. M's office, [address], on the following dates since the accident:

The subject's first visit to Dr. M was on July 6, 1976 (after his release from hospital).

Diagnosis

At that time the subject's situation was diagnosed as:

1. Headaches
2. Dizziness
3. Difficulty Walking

The subject attended at Dr. M's office on:

July 13, 20, 1976

August 17, 30, 1976

September 14, 20, 1976

October 19, 1976

November 17, 1976

January 4, 1977

February 8, 1977

March 8, 1977 the subject attended at his doctor's office.

Diagnosis

The subject's situation was diagnosed as:

1. Still Deaf
2. Restricted in Sports

Previous Treatment

While probing into the subject's previous treatment we learned that during 1971-72 he was treated by Dr. M who, as mentioned above, is the subject's physician. At this level we checked and found that Dr. M is a General Surgeon.

Relying on the above mentioned information, we extended our effort and learned that the subject was referred to Dr. F, the Ears, Nose and Throat specialist at the Toronto General Hospital after the accident.

Medical Information Pertaining
Ears, Nose and Throat Specialist

During our extensive medical investigation we learned that the subject attended at the Toronto General Hospital for treatment by Dr. F on a few occasions at which time he was tested (hearing) and x-rayed.

Further investigation revealed that the subject sustained head concussion as a result of the motor vehicle accident which resulted in total deafness on one side. The subject sustained temporal bone fracture on the left side and lost hearing in that ear.

Diagnosis

The subject last saw Dr. F on December 18, 1976 at which time his situation was diagnosed as:

1. Left Peripheral Hearing Loss
2. Auditorial Lesion

Pertaining your direct question in your written instructions whether or not the subject's deafness is a direct result of the accident, we have extended our effort in this respect and while probing into medical confidential information (consisting of Dr. F's treatment) we learned that the subject's deafness probably resulted from the motor vehicle accident. While pressing in order to obtain a more direct answer to this question we learned that this fact cannot be positively confirmed in spite of the fact that the subject had no hearing problem prior to the accident.

Conclusion

We have conducted an extensive medical confidential investigation while elaborating on each and every question and situation you touched in your written instructions and we are reporting the information as obtained for any step you may find necessary.

If any further investigation is required please contact our office.

This is a typical report and it illustrates the kind of confidential health information obtained by Mrs. Presement and provided to Mr. Franco's clients.

Approximately four or five times a year, Mrs. Presement called the first-party insurer. Mandatory accident benefits are paid for the period of complete and continuous disability to a person injured in a motor vehicle collision who was a passenger riding in a motor vehicle insured under a standard insurance contract evidenced by a motor vehicle policy or who was struck by an insured vehicle. To obtain those weekly benefits, the claimant is required to submit medical information to the insurer who is known as the first-party insurer. Mrs. Presement (and many other investigators) approached the first-party insurer and obtained particulars of the medical information submitted by the injured person being investigated in support of the application for accident benefits without the authorization of that person. I was told that in very few cases did a first-party insurer fail to provide this information on request. This was nothing more than reciprocity because the first-party insurer might be the third-party insurer in the next case. In this sort of case, by properly identifying herself and the interest she represented, Mrs. Presement was able to obtain confidential health information from the first-party insurer. No pretext was necessary.

Mrs. Presement admitted that, at the time she made pretext calls, she knew that physicians, physicians' employees, hospitals and hospital employees were obliged to keep health information about their patients confidential. She admitted that, in fact, she had been tricking these persons into releasing this information. She said that she had never asked Mr. Franco, any insurance company, or any lawyer whether the practice was improper. She said that she believed that the ethics of her profession permitted her to make pretext calls of the kind I have described. I found Mrs. Presement to be rather naive. I accept her statement that she assumed that, since Mr. Franco's clients were reputable insurance companies, adjusters and law firms, they would not ask her to do anything illegal and that, therefore, if they requested her to make pretext calls, those calls must have been legal. This was a perfectly rational assumption for Mrs. Presement to make in her circumstances until June, 1977. However, in June, 1977, a directive about pretext calls from the Registrar of Private Investigators and Security Guards came to her attention. This important directive, sent to all licensed private investigators, I now reproduce in its entirety.

Ontario Provincial Police

June 13, 1977

TO ALL PRIVATE INVESTIGATION AGENCY HEADS
AND BRANCH OFFICES

RE: MISREPRESENTATION OF INVESTIGATION

Dear Sir:

The Registration Branch has received a number of complaints concerning private investigators who are deliberately misrepresenting their identity in attempts to obtain information. For example, a private investigator recently misrepresented himself as a doctor to obtain information from hospital records. Such conduct is a matter of concern to medical groups and the public in general, and I share this concern. It is sometimes difficult to discern the permissible limits, but I urge you to consider carefully whether the ruse is justified in the circumstances of the case. I am forced to take action under the Private Investigators and Security Guards Act, where I find that such conduct is not in the public interest.

Among those misrepresentations which I do not consider to be in the public interest and which I will not countenance are the following:

- (a) Impersonation of a doctor or a person working under his authority;
- (b) Impersonation of a lawyer or one working under his authority;
- (c) Representing oneself as being in any way connected with government (federal, provincial, municipal, Crown Corporation, etc.);
- (d) Representing oneself as being in any way connected with the administration of

Justice (Crown Attorney, Judge, Sheriff,
or their staff);

(e) Representing oneself as being in any way connected with police. This is, of course, an offence under the Private Investigators and Security Guards Act, and may be an offence under the Criminal Code of Canada.

There may be other ruses and pretexts which are equally objectionable. However, at this time, I am most concerned with those mentioned above. Accordingly, you are requested, if you or anyone under your direction are engaging in these misrepresentations, to refrain from doing so immediately. You are further requested to bring contents of this letter to the attention of private investigators licensed with your firm.

As I have mentioned, these investigative techniques are not in the public interest, and should it come to my attention that firms or private investigators persisted in using these subterfuges, then I will proceed against their licences in accordance with The Private Investigators and Security Guards Act.

Yours very truly,

J.C. Villemaire
A/Chief Inspector
Registrar/Director
Private Investigators and
Security Guards Section
Registration Branch

JCV/tf

When she became aware of this directive, Mrs. Presement ought to have realized that, since she had been implicitly representing herself as an employee of OHIP, she should stop making calls of that sort. At the very least, she should have sought an explanation from the Registrar or an opinion from Mr. Franco or his solicitors. In June, 1977, she must have known that this memorandum was directed to the kind of pretext

she had been using because, by her own admission, she knew that OHIP was part of the Ministry of Health and part of the Provincial Government.

As I have said, Mr. Franco testified that he accepted responsibility for all of the actions of Mrs. Presement. She was, after all, at all times, working under his direction and control. Despite his knowledge of the duty of confidentiality on the part of physicians and hospitals, Mr. Franco accepted assignments from insurers and adjusters that required him to attempt to cause persons to breach this obligation. He did so because he wanted to remain competitive in the investigation business. It is clear to me that from about 1974, because Centurion Investigation Ltd. had begun to refine the technique of obtaining confidential medical information without authorization, there was enormous pressure on all its competitors to provide a similar service to their clients who had come to expect and demand such information. Certainly Mr. Franco's operation was on a much smaller scale than that of Centurion Investigation Ltd.

The corporations listed below were Mr. Franco's clients and received investigation reports containing confidential health information obtained without the claimants' consent. I accept Mr. Franco's evidence that he was expressly instructed by his customers to seek this information. I believe that all of them and those of their employees who instructed Mr. Franco knew or ought to have known that hospitals, hospital employees and physicians and their employees had an obligation to keep the contents of the health records of the patients confidential and ought to have accepted this principle. They instructed Mr. Franco to carry out investigations when they knew or ought to have known that, during these investigations, Mr. Franco would obtain confidential health information without the consent of claimants. They ought not to have done so.

Royal Insurance Company of Canada
Fireman's Fund Insurance Company of Canada
Adamsons Limited
Commercial Union Assurance Company of Canada
Gibralter General Insurance Company
Pinkerton Insurance Adjusters

Albert George Oxlade and Griffin Investigation Agency

Albert George Oxlade became a licensed private investigator in 1967, and in 1974 he began carrying on business as Griffin Investigation Agency, to be referred to as Griffin. In 1976, he began to obtain confidential health information using pretexts. These pretexts were made by his employees with his knowledge and, on occasion, by himself. He normally read all investigation reports before their delivery to his clients to ensure factual accuracy and proper grammar, and therefore, he had actual knowledge of the information sought and received by his employees.

Mr. Oxlade testified that he did not know that hospital employees and physicians had an obligation in law to keep health information about their patients confidential and that he believed that physicians could freely tell anyone anything about their patients. I find this to be incredible and I do not think that he believed what he said. Mr. Oxlade admitted that he knew that physicians ran the risk of having their licences to practise suspended if they divulged confidential health information about their patients. That was an admission that he realized that there existed a legal sanction which could be used against a physician if he or she violated his or her obligation of confidentiality. Furthermore, the use of pretexts by Mr. Oxlade and his employees was inconsistent with an honestly held belief that physicians and hospital employees could freely disclose to anyone anything that they wished about their patients.

Frequently Griffin's staff used a shopping survey pretext which was similar to the Centurion pretext discussed in the part of the report dealing with the practices of Centurion Investigation Ltd. Griffin's employees also used a "Night Out Magazine pretext". This was an attempt to sell to the subject a magazine which highlighted the night life in Toronto. The theory was that a totally disabled person would be disinterested in such a magazine and, certainly, if there was a refusal by the subject to purchase the magazine, an opportunity for a discussion would ensue about the reason for the refusal which, if properly developed, would lead to a description of physical disability by the subject.

The mainstay of the Griffin repertoire was the independent adjuster description. The investigator would, for example, attend upon a hospital employee and identify himself as an independent insurance adjuster. Mr. Oxlade testified that the description "private investigator" had an unsavoury connotation because people had a misconception of the function of a private investigator, having watched the Rockford Files too often on television. I do not believe that that was the true reason for the representation. I am confident that the use of the description "independent insurance adjuster" was an attempt to project an idea of neutrality or, even of a unity of interest with the patient. Given that description and its connotation, physicians or their employees or hospital employees, thinking that they were likely to be aiding their patient in a resolution of any claim, would be more likely to cooperate by providing the requested information. Mr. Oxlade denied that identifying a private investigator as an independent insurance adjuster was the use of a pretext. To my mind, an intentionally false identification of a private investigator as an independent insurance adjuster is a misrepresentation or trick utilized specifically to cause a person to impart information and is as much a pretext as a false representation that a person is an employee of OHIP.

After reviewing approximately 41 investigation reports which were prepared in the year 1977 by Griffin, all of which contained confidential health information obtained without the patients' consent, I have concluded that Mr. Oxlade and his employees sought confidential health information from hospital employees, physicians and their employees, and others under a duty to keep such information confidential by the use of pretexts in the knowledge that all of these persons had an obligation to keep that information confidential. I am equally certain that Mr. Oxlade and his employees knew that this confidential health information would not have been disclosed to them had they fully and frankly identified themselves as private investigators acting on behalf of an insurance company adverse in interest to the patients.

When pretexts had been resorted to, the Griffin reports always disclosed to the client that they had been used to obtain confidential health information. The usual phrase contained in most reports was "by the use of a suitable pretext". The report would then go on to name the source of the information and to specify the information obtained. The evidence made it clear that the phrase "suitable pretext" really meant "successful pretext". Mr. Oxlade did not always frankly disclose to his clients that he or his employees had approached the claimant himself or herself under pretext because to do so, on some

occasions, meant acting contrary to the express instructions of his clients. There is, however, no doubt that Griffin's clients expected to receive confidential health information obtained without authorization, and asked that such information be sought.

A close analysis of a large number of Griffin reports is unnecessary. It will be helpful to refer to Griffin's access to confidential information to illustrate the extent to which confidential health information is retained in various locations in our society, locations which have proved vulnerable to invasion. I need not provide additional examples of information obtained from physicians, physicians' employees, and hospital employees. Other sources are discussed below.

On April 6, 1978, Mr. Oxlade received an assignment requiring him to determine the extent of injuries suffered by two claimants in a motor vehicle collision on February 23, 1977. The subjects' insurer was the Fireman's Fund Insurance Company which, under The Insurance Act, R.S.O. 1970, chapter 224, was paying mandatory medical, rehabilitation, and accident benefits under the governing insurance policy.

By calling and visiting Fireman's Fund Insurance Company on April 13, 1977, Mr. Oxlade received confidential health information. Mr. Oxlade reported to his client, The Co-operators, on May 1, 1978, in the following language:

Thursday April 13, 1978

9:30 a.m.

The second day's investigation of the subjects was commenced.

The subject's carrier, Firemans Fund Insurance, 321 Bloor Street East, Toronto, (963-7208), was telephoned in order to secure data regarding the accident history of both the male and female subjects.

Ms. Hannah Snajdman of the claims department was spoken with again and she related that the male subject is the policy holder and that he obtained his automobile coverage under policy number through Harwood Insurance Agency. She stated that at the present time neither she nor the underwriting department could locate the subject's policy so that they would only be able to provide data about the February 23,

1977 accident. Regarding _____'s injuries in that accident, Ms. Snajdman related that she received a medical report from the subject's family physician, Dr. H, dated March 12, 1977 in which he wrote that he first examined the subject on March 8, 1977 regarding his February 23, 1977 automobile accident. Dr. H wrote that the subject had contusions to the parietal in the left side of his head, contusions to his nose with reoccurring epistaxis. He further wrote that he had a reactive anxiety status and post traumatic neurosis. She stated that Dr. H prescribed "percocet, valium, otravine nasal spray" and a soft-roll cervical collar that he was to wear for 2 weeks. He further recommended that he take physiotherapy and receive a lot of 'reassurance'. Ms. Snajdman was unable to explain Dr. H's remark about "reassurance". The prognosis as written by Dr. H was that the subject would make a slow, gradual prolonged recovery and that he would be experiencing some pain for a period of two to sixteen months.

The next report received by Ms. Snajdman was dated April 29, 1977 in which Dr. H wrote that he had last examined the subject on April 27, 1977. Dr. H wrote that the subject was experiencing pain to his cervical back and was restricted in his neck movements. In addition, he had a sore nose and was also restricted in his arm and shoulder movement. Dr. H wrote that he told the subject to continue with his physiotherapy and to start ventilation therapy. He wrote further that he expected him to return to his normal duties at work on May 26, 1977. Ms. Snajdman related that as they did not receive any additional medical reports from Dr. H, they stopped the subject's benefit payments of \$10.00 per day effective May 26, 1977.

With respect to the female subject, Ms. Snajdman suggested that as her file on her is very extensive, her office should be

attended in order to obtain any required data.

10:15 a.m.

The investigation was temporarily discontinued.

1:30 p.m.

The investigation was at this time, recommenced.

2:00 p.m.

The offices of Firemans Fund Insurance, 321 Bloor Street East, Toronto, 9th floor, were attended in order to obtain data regarding the female subject's injuries sustained in the accident of February 23, 1977. Subsequently Hannah Snajzman, the adjuster of record was again spoken with and she proved to be cooperative.

Ms. Snajzman related that the female subject was involved in the motor vehicle accident of February 23, 1977 and that as a result of the accident sustained:

- 1) head and facial injuries with:
 - a) cerebral concussion
 - b) fractured nose with recurrent epistaxis
 - c) right orbital ecchomosis (black eye)
- 2) whiplash injury to neck of moderately marked severity
- 3) strain, dorcile-lumbar back of milder severity
- 4) reactive anxiety state (post-traumatic psychological effect of the accident).

She stated that the subject was confined to hospital from February 23, 1977 until February 27, 1977 and was given various drugs to reduce the pain and to assist in relaxing the muscles. Ms. Snajzman related that she received a medical report from Dr. H, family physician and psychiatrist,

dated March 12, 1977 in which he wrote that the subject was making slow progress; prolonged gradual clinical course of improvement is expected with this type of severity. Dr. H also indicated that complete recovery could probably be achieved in the next 16-20 months. She stated that various other medical reports received from Dr. H, Dr. R, Dr. M, and Dr. A reconfirmed the above diagnosis and that they were unable to state as to when the female subject could return to work. Although the injury to the subject's nose has completely recovered, she is still experiencing moderate pain to her neck and shoulder and back area, and as well is suffering from a continuous state of anxiety. Ms. Snajzman related that because of the medical data that they have received from the various physicians, she has paid the subject \$70.00 per week from the date of the loss to the present time. She stated that the benefits will run out by the end of June and as she is suspicious of the subject's claim, she is giving serious consideration to authorizing an investigation into her current activities.

3:30 p.m.

The investigation was discontinued for the day.

With his investigation report Mr. Oxlade enclosed 12 medical reports which he had obtained from Fireman's Fund Insurance Company.

Recommendation:

5. That in order to prevent an insurer who obtains health information under Schedule "E" of The Insurance Act from voluntarily disclosing it to a person or corporation adverse in interest to the insured, the Act impose an obligation of confidentiality upon every insurer in respect of that information, provided, however, that if the Schedule "E" insurer is also the third party insurer it may use the information for the

purposes of any claim against the insurer of its insured.

Mr. Oxlade testified that his employees regularly contacted the Workmen's Compensation Board. In connection with one report before me, the investigator contacted the Workmen's Compensation Board by telephone, at 2 Bloor Street East, Toronto, and spoke to an unidentified clerk. The investigator learned that the subject had been involved in an accident on September 19, 1970, while employed by the Department of National Defence and had sustained a back injury. He was given the actual claim number.

It was Mr. Oxlade's usual practice to contact an employer to determine whether there was sickness and accident insurance provided at the place of employment. If that insurance was available, he would determine the name of the insurer and contact that company. He said that his employees were successful in obtaining confidential health information from sickness and accident insurers in approximately 50 per cent of their attempts.

Mr. Oxlade testified that from time to time he approached the Criminal Injuries Compensation Board in an attempt to review its files and was reasonably successful in obtaining access to the health information the Board had.

Mr. Oxlade was reluctant to be frank in his testimony and his attitude was belligerent. It is significant that he and his staff continued to attempt to obtain health information by pretext as late as May, 1978, at a time when wide publicity had been given to our hearings into the investigation industry. At this time, by virtue of this publicity, Mr. Oxlade had direct notice of the impropriety and illegality of his acts. In essence, his position was that once an injured person asserted a claim against an insurance company, he was "fair game" and could be tricked into disclosing confidential information. He also said that insurance companies were big business and were prepared to make any acknowledgment that might terminate their involvement with our investigation and hearings, although when pressed, he stated that he did not want me to infer that the executives of such companies were insincere in their acknowledgments of wrongdoing. In my opinion, that is precisely what he did imply. Mr. Oxlade made, and then withdrew, an allegation that I would not fully explore the involvement of the legal profession in the obtaining of confidential health information because, although I was prepared to expose others, I would protect lawyers who had been guilty of the same kind of conduct.

I found Mr. Oxlade to be inconsistent, irrational and stubborn. Despite his knowledge of the impropriety of causing hospital employees and physicians' employees to breach their duty, he said that he still considered it to be perfectly proper for him to approach those persons to attempt to obtain confidential information by use of his independent-insurance-adjuster pretext.

Recommendation:

6. That private investigators licensed under The Private Investigators and Security Guards Act be prohibited from representing that they are insurance adjusters.

Allstate Insurance Company of Canada, which I shall call Allstate, is a casualty insurance company carrying on business in Canada. In Ontario, in 1978, Allstate employed approximately 175 persons who were involved in the adjusting of casualty losses. The records seized from Griffin revealed 51 investigation reports in which Allstate had retained Griffin and requested or received health information about claimants. Only nine of these reports were tendered in evidence. However, there is no doubt that Allstate and its employees actually knew that Griffin had been obtaining health information in some improper manner without the patients' authorization.

Herbert Hickling, Assistant Vice-President of Claims, who had been associated with Allstate for approximately 22 years, approximately 16 of which were in the claims area, appeared on behalf of Allstate and made the acknowledgment and undertakings in the usual form. As Allstate was Mr. Oxlade's largest customer, I concluded that Mr. Oxlade had meant that in its undertaking Allstate could not be sincere.

Mr. Hickling was present when Mr. Oxlade made his statement about insurance companies generally and he assured me that Allstate did not operate in the fashion suggested by Mr. Oxlade and that it had, in fact, given considerable thought to the acknowledgment and undertakings given. He pointed out that it was a corporate decision made by persons who were in authority and who had the capacity to make such a decision and that I would be justified in relying upon those admissions and undertakings as sincerely given. I was impressed with Mr. Hickling and I accept his evidence in preference to that of Mr. Oxlade and conclude that the undertakings and acknowledgments were given sincerely and with the intention that they be acted upon.

One law firm was a Griffin customer. As I have already indicated, I propose to deal with all lawyers involved in this type of practice at the same time, later in the report.

W.A. King Ltd. and C.C.R.

W.A. King Ltd. is a corporation licensed as an independent insurance adjuster. Its three shareholders are Geoffrey K. Taylor, Edward D. Gooderham, and Charles Clarke Wright. In 1973, W.A. King Ltd. decided to enter into the private investigation business. The initials C.C.R. were chosen because they were the first three initials of Retail Credit Company of Canada Ltd. reversed. Originally, W.A. King Ltd. carried on business as Canadian Consumer Retail Association. In the spring or early summer of 1975, the name was changed to Canadian Claims Research. As a matter of business practice, however, the business was always known as C.C.R. and I shall refer to it in that way. On May 9, 1978, W.A. King Ltd. ceased carrying on business as Canadian Claims Research and a company named 383285 Ontario Limited was incorporated to carry on the investigation business.

At all times, W.A. King Ltd. also carried on business as an independent adjuster, employing six adjusters and a staff of 14 employees in 1978. Throughout the period I am interested in, the adjusters and the investigators were located at the same address and operated from the same office. The adjusting and investigation operations were separated by an unlocked door. Both operations shared a common bookkeeper. All files were kept separately. The adjusters had access to all C.C.R. files and, in fact, Mr. Wright was concerned with quality control of investigation files. There was no restriction on the right or the ability of investigators to inspect adjusters' files. The evidence indicated that 16 per cent to 20 per cent of C.C.R.'s business related to cases assigned by W.A. King Ltd. When C.C.R. was first established in 1973, Mr. Wright had a letter sent to all prospective customers setting out, among other things, the relationship between W.A. King Ltd. and C.C.R. However, thereafter W.A. King Ltd. did not, as a matter of practice, disclose, whenever it recommended to its customers or clients that an investigation be carried out, that there was an affiliation between W.A. King Ltd. and C.C.R. Nor did C.C.R.'s letterhead disclose that W.A. King Ltd. was carrying on business as C.C.R.

C.C.R. investigators regularly obtained confidential health information without the patients' consent from physicians,

physicians' employees and hospital employees. In this respect they were much like many other investigators who appeared at our hearings. However, C.C.R. reports regularly contained substantial confidential health information obtained from the Ontario Health Insurance Plan. No other investigation agency could match C.C.R. in quantity or quality of information obtained from OHIP. I shall review the activities of the C.C.R. investigators with respect to the obtaining of health information generally and OHIP information particularly.

Frank Joseph Oliva is an experienced private investigator. He worked as an investigator for Retail Credit Company of Canada Ltd. from 1963 to 1973. From 1973 he was employed by C.C.R. From time to time during his investigation career, Mr. Oliva approached hospitals, hospital employees, physicians and physicians' employees in an attempt to obtain health information about patients without their authorization with the full knowledge and approval of C.C.R.'s principals. He conceded that he knew that the physician-patient relationship was "as a rule, confidential". But he went on to say:

It was my business to ask the doctor for the information. Now, if a doctor chose to give us any, fine. If a doctor chose not to give it to me, I would put it in the report....I would say that really the doctor did have the discretion to make and keep that information confidential. If he wanted to release it, that was his business....

Mr. Oliva acknowledged that under The Private Investigators and Security Guards Act, R.S.O. 1970, chapter 362, an investigator had an obligation of confidentiality with respect to information coming into his possession during the course of his duties. In fact, it was his practice, even when directly asked by the person from whom he was seeking information, to refuse to disclose the name of his principal, without the consent of the principal, because he understood that he had an obligation to keep that information confidential. I find it incredible that he did not realize that a physician had, at the very least, a similar legal obligation, although he might well have been unaware of the precise governing statutory provisions. Furthermore, the use of pretexts by Mr. Oliva is inconsistent with any honestly held belief on his part that physicians could, as a matter of discretion, disclose to anyone anything they wished about their patients. Also inconsistent with this view was a statement contained in a report prepared by him. After becoming aware the claimant had been involved in a previous accident he said to his client:

It is possible that you people do have medical authorization from the subject, possibly from the earlier condition. It would be interesting to check that chart to see if this actually does belong to the claimant.

Although Mr. Oliva denies that he was suggesting that the insurer use an authorization given in another proceeding to obtain health information, I have no doubt that that is precisely what he intended.

Two typical examples of the kind of health information obtained by Mr. Oliva and recited in investigation reports prepared by him are set out below:

File No. 151

Business Office,
Grace Hospital,
650 Bloor Street,
Toronto, Ontario,
May 24, 1974.

We contacted the business office in order to try and get some details regarding the confinement of [redacted] in April, 1974. According to her records, the subject was confined to hospital from April 6th, 1974 until April 21st, 1974. She had semi-private coverage and all of the bills were paid apparently by the Blue Cross policy which she carried. The business administration office is not able to supply us with any other details regarding the reason being confined to hospital and indicated we would have to contact the Medical Records in order to try and obtain any information in this respect. As we have no medical authorization, we felt that very little information could be obtained through the hospital, however, we attempted to obtain this information for you.

Medical Records,
Grace Hospital,
650 Bloor Street,
Toronto, Ontario.

We were fortunate in contacting a source here who indicated that your subject was confined to this hospital from April 6th to the 21st of April, and the reason for the confinement was an operation to [redacted], this being a total abdominal hysterectomy. It was performed by a Dr. H located on Bloor Street. We later checked this in the telephone directory and found it to be listed at [address] and this doctor is in obstetrics and gynecology specialist. It would appear therefore that the confinement to the hospital from April 6th to the 21st of April, 1974, had no bearing whatsoever on your accident, however, was merely a normal total abdominal hysterectomy which was performed on your claimant....

File No. 114

We further investigated the subject through the attending physician, who is a Dr. B, formerly located in [redacted], Ontario, operating out of the [redacted] Clinic. However upon investigating at the address, we found that Dr. B has since moved away from this location and we finally located this doctor presently practising out of [address], Ontario.

Upon contacting Dr. B, although we did not speak to him personally, we did speak to his secretary out of the Newmarket office, and she indicated that Dr. B did not take any of the files on patients he had when he was operating out of [redacted], Ontario, however, the doctor apparently recalled the name when she spoke to the doctor, and indicated the best way to get any information on the subject would be to contact the [redacted] Clinic, in [redacted], Ontario.

As we did not want to conduct a further trip to [redacted], Ontario, we contacted the [redacted] Clinic by telephone, [telephone number], and we spoke there with a Dr. C who apparently operates out of that Clinic.

According to Dr. C in the Clinic, he saw the subject himself on the 7th of March, 1977. The Claimant apparently came to him in order to get her referred to an orthopaedic specialist, at the request of her Lawyer. He did have the full Medical Report of the Claimant in front of him, this would be the report which was actually sent to Liberty Mutual; and he confirmed the information that was in the original report. The subject did suffer a strain to the lower thorax area, and also the upper lumbar vertebrae area. The subject was declared fit for work as of the 16th of February, 1977.

The subject was not examined by this source on March 7th, 1977 however she was given an appointment to see an orthopaedic specialist in , Ontario, this being a Dr. Be, Orthopaedic Surgeon, located at [address] Charlotte; his full name actually is Be, Orthopaedic Surgeon, [telephone number], and as indicated earlier, located in the area.

Dr. Be, in turn, wrote a full report to Dr. C here in and he did have the full report of Dr. Be in front of him. He read part of the report to this Investigator, and in summary it appeared that the subject was x-rayed when she attended this specialist in , and the x-rays all appeared to be okay and he indicated that she will continue to improve and she had in fact suffered a mild muscle strain in the lumbar area, in the accident of January 8th, 1977.

The report unfortunately does not really make any mention as to whether the subject was totally disabled at that time, although from what he read to us, it appears that certainly he did not find anything of a serious consequence wrong with the subject at that time.

As you note from the partial report, she will continue to improve, so obviously she was possibly suffering some rather mild after effects from the injury at that time.

It should be noted that after the doctor supplied us with information up to this point, he rather questioned who we were representing at this time, and although we did not specify to him the name of the Company for whom we are presently investigating, he became rather hesitant in supplying us with any further information, other than that he had given us up to this time, and indicated that really if we supplied him with a medical authorization, he would be able to release all of this information to you.

We indicated that if we do obtain one, we will of course forward everything to him, and he will in turn forward to us the report we require.

No further information could be obtained from this source.

It should be noted that the appointment was set up to see Dr. Be on the 23rd of March, 1977.

The first example, File No. 151, clearly indicates that Mr. Oliva knew that very little information would be obtained from a hospital without the patient's authorization. Again, this is inconsistent with any honestly held belief that physicians and hospital employees have a discretion to release information about patients without their consent. Mr. Oliva sought confidential health information from hospital employees, physicians and their employees and others under a duty to keep such information confidential by the use of pretexts, with the knowledge that all of these persons had an obligation to keep that information confidential. I am certain that Mr. Oliva knew that this confidential health information would not have been disclosed to him had he fully and frankly identified himself as a private investigator acting on behalf of the insurance company adverse to the interests of the patient.

Mr. Oliva never personally contacted OHIP to obtain health information but always, during his employment by both C.C.R. and Retail Credit Company of Canada Ltd., had Albert Joseph White, a fellow investigator, do so on his behalf. Mr. Oliva testified that he believed that the information which Mr. White obtained for him came from an OHIP employee, Charles Gordon. He testified that it was Mr. Gordon's job to provide such

information to the insurance industry, that he was acquainted with Mr. Gordon and that he believed that Mr. Gordon would provide him with similar information if he requested him to do so. He said, however, that he always asked Mr. White to obtain this information because he did not want to affect Mr. White's remuneration and interfere with what he termed a working relationship between Mr. Gordon and Mr. White. I do not accept the claim that Mr. Oliva honestly believed that Mr. Gordon would provide him with the same type of information, or, indeed, any information. Had Mr. Oliva honestly believed that, he would have sought the information himself. Mr. White always charged a fee based on one hour's work when he provided OHIP information to other investigators and, to that extent, Mr. Oliva's earnings, which depended upon the fees charged for the preparation of every report, were thereby reduced. It is incredible that over an extended period of time Mr. Oliva would not have contacted OHIP, at least on a few occasions, if he had honestly held this belief.

The following is an extract from a report prepared by Mr. Oliva containing OHIP information obtained by Mr. White for Mr. Oliva:

In the meantime we had also contacted OHIP people to try and ascertain a new address for the subject and also try and obtain some information regarding the subject's file with them and as far as they were concerned the file is closed, no recovery obtained, they only had the address of for the subject, their file number . They had several treatments for physiotherapy and also for psychotherapy, according to their file the total payout was \$195.40. The results indicate he saw Doctor C, Doctor T.

Gerald Donald Davies became licensed as a private investigator in January, 1971. He was employed by C.C.R. from February, 1978, to August, 1978. On approximately two occasions he contacted the OHIP subrogation department and spoke to Ross Petit of that department who refused to give him any information. Mr. Petit did not advise Mr. Davies that Mr. Gordon or any other person was the liason officer with the insurance industry and was a person from whom he would be able to obtain OHIP information. Mr. Davies's experience led him to believe that he simply was unable to obtain information from OHIP.

John Brian Duff obtained his licence as a private investigator in 1965 and worked first for Retail Credit Company of

Canada Ltd. He was one of the founders of C.C.R. but left after a falling out with Mr. Wright. I approached Mr. Duff's evidence with caution because of this animosity and because I concluded that he was less than candid. For example, he denied knowing what a pretext was and denied ever carrying out an "indirect interview" despite the fact that a report prepared by him contained this language:

The claimant was taken to Northwestern General Hospital for treatment immediately following the accident. However, we have experienced difficulty in obtaining medical details from this area. Through a very indirect, dissimulative approach, we were able to obtain the name of the attending physician, Dr. A, and his address.

His explanation of the phrase "very indirect, dissimulative approach" was evasive and incomprehensible. He said that this could mean that the approach was direct, honest and straightforward and, in fact, he said that he sometimes means the opposite of what he says.

Mr. Duff also said that he did not think that physicians had an obligation to keep health information about their patients confidential. I do not accept his statement of his belief and I conclude, on all of the evidence before me, that he knew that he had to carry out indirect interviews to succeed in obtaining health information without authorization of patients.

Mr. Duff never obtained or attempted to obtain information from OHIP while working as a private investigator because he believed that he was not entitled to the information and could not obtain it. He believed that it was necessary to have a truly confidential source to obtain information of that kind. He believed that Mr. White had such a source both because he had heard Mr. White on the telephone and because he was aware that Mr. White was obtaining OHIP information for other C.C.R. investigators who included the information in their reports.

Terry Adam Power had been a licensed private investigator for 13 years. First employed with Retail Credit Company of Canada Ltd., he joined C.C.R. at its inception. Mr. Power was a resourceful investigator who had had truly confidential sources at the Unemployment Insurance Commission, the Metropolitan Toronto Social Services Department and the Metropolitan Toronto Police Department.

Mr. Power never personally attempted to obtain information from OHIP. He had no source there. On approximately six occasions Albert White obtained the necessary OHIP information for him and this information was included in his reports. Mr. Power said that, if he had tried, he probably could have obtained OHIP information but he did not do so because Mr. White was more familiar with the workings of OHIP and knew someone there. Therefore he channelled his requests through Mr. White. I do not accept this as an honest expression of Mr. Power's belief. Mr. White was paid a portion of the fee generated from every report in which information obtained by him from OHIP was included. Mr. Power struck me as an individual who would have exploited any possible source of information if he had reasonably believed that he could obtain information. He did not attempt to obtain information from OHIP because he believed that he would not be successful without the subscriber's authorization.

Philip Basil Mangoff is a licensed investigator and has been in the investigation business since 1957. To say that he is experienced is an understatement. Mr. Mangoff knew that OHIP employees had an obligation of confidentiality and ought not to provide information without a subscriber's authorization. In fact, one investigation report prepared by him tells of an attendance at OHIP and an attempt to obtain information from the subrogation department. He was interrupted while speaking to a clerk by S. Badham, a supervisor, who advised him that no OHIP information could be released to him. On another occasion, in November, 1974, he contacted Richard T. Godden in the subrogation department. Mr. Godden advised him that he had received express instructions that no information was to be provided from subrogation files without subscriber authorization. From time to time, Albert White, another C.C.R. investigator, obtained confidential health information from an OHIP employee, who was termed a "confidential source", for inclusion in Mr. Mangoff's reports. When he received this information Mr. Mangoff believed that this was information that he, himself, was not entitled to receive. Mr. Mangoff candidly admitted attempting to obtain health information by pretext. I am satisfied that he did so in the knowledge that it was improper. No useful purpose would be served by setting out examples of his reports. They are similar to those prepared by Mr. Oliva.

Stephanie Ann Phillips has been a licensed private investigator since February, 1972. Her early training as an investigator was with Retail Credit Company of Canada Ltd. She was employed at C.C.R. from the period of May, 1973, to January, 1975. She candidly admitted, during this and the earlier period at Retail Credit Company of Canada Ltd., approaching hospitals

and physicians to seek health information. She said that she had been instructed, early in her career at Retail Credit Company of Canada Ltd., that "one was supposed to attempt to obtain whatever medical information might be available."

Miss Phillips admitted that she had had access to a confidential source at The Wellesley Hospital until 1974. I did not require this confidential source to appear at our hearings because he or she no longer worked at The Wellesley Hospital and was no longer readily available to give evidence. Miss Phillips testified that she had not given any thought to whether persons such as her confidential source at The Wellesley Hospital had an obligation to keep information confidential.

While at C.C.R., Miss Phillips believed that a fellow investigator, Albert White, had access to confidential OHIP information through a source employed at OHIP. Mr. White obtained confidential information from OHIP for her on one occasion. Miss Phillips was a credible and helpful witness whose evidence I accept. Her involvement in the obtaining of health information was infrequent. She certainly was not as sophisticated in these matters as Messrs. White, Oliva and Mangoff.

Albert White is an extremely experienced investigator. He was employed at Retail Credit Corporation of Canada Ltd. from 1957 to 1973. In 1973, he joined C.C.R. and was still employed with that company when he gave evidence at our hearings in September, 1978.

Mr. White knew that physicians, physicians' employees, and hospital employees and other health-care providers such as chiropractors have an obligation to keep patient information confidential and not to release information about a patient without his or her authorization. He knew that every physician had a licence and was aware of physicians losing their licences for practices which might be considered professional misconduct. He also knew that he, as an investigator, had an obligation to keep information which came into his possession confidential and that he might lose his licence for breach of this obligation. Despite this knowledge, he contacted physicians, physicians' employees, hospital employees, and chiropractors and attempted to persuade them to provide information to him with respect to patients in whom he was interested in the face of this obligation of confidentiality. He did this because, as he said:

That is the whole basis of the insurance investigation business...to gather information which is not readily available....

I conclude that Mr. White sought confidential health information from hospital employees, physicians and their employees and others under an obligation to keep such information confidential, such as employees of the Municipality of Metropolitan Toronto's Social Services Department and chiropractors, knowing that all of them had an obligation to keep health information confidential.

Had Mr. White's activities stopped at this point, he would have been indistinguishable from many other investigators referred to in this report. However, Mr. White, by his own admission, obtained substantial confidential health information from OHIP for inclusion in his own reports and the reports of fellow investigators. We had evidence of 57 contacts between Mr. White and OHIP. Thirty-nine investigation reports in which OHIP health information, in varying amounts, had been given to Mr. White were filed as exhibits at our hearings. In all of his investigation reports, Mr. White referred to the person from whom he obtained this information as a "confidential source". I have pointed out that many investigators equated an anonymous source with a confidential source who was a known person, and who, because of a relationship with an investigator, provided information. Mr. White truly had a confidential source at OHIP. He was Charles Gordon.

It was admitted by Mr. White that, except in those cases to which I will specifically refer, all information attributed to a confidential source at OHIP had been provided by Mr. Gordon to Mr. White. This information was included in Mr. White's reports or reports prepared by other investigators. Because the magnitude of the disclosures cannot otherwise be appreciated, and at the risk of taxing the reader's patience, I set out below extracts from some of the investigation reports filed as exhibits at our hearings.

File No. 133

PAST HEALTH HISTORY:

We learn of a congenital eye defect, but details are not available. It apparently requires only a periodic check-up or appraisal, as the O.H.I.P. medical record shows. There is no indication of any other past health history, and the boy is described as having had a good healthy childhood up to this point. No prior injuries or periods of disability.

MEDICAL:

We learn of no current medical treatment, and sources indicate no obvious need for same. The last recorded medical treatment, as per O.H.I.P. records, was December 6th, 1972, while he was still a patient at Sick Children's Hospital. We understand that he has been treated by Dr. H, who is known as a pediatrician, on the staff at the Hospital for Sick Children, Toronto. We understand that you have a list of names of other doctors who have treated, apparently all of these at the hospital. As we discussed, no attempt was made to contact these doctors, in view of Mr. [REDACTED]'s awareness of our investigation, plus the need to obtain from the [REDACTED] family signed authorization for the release of this medical information.

File No. 134

Confidential Source
Toronto, Ontario
September 20th, 1973

Our source has access to confidential OHIP records and with the claimant's OHIP number, he obtained a print out of benefits paid to [REDACTED] and/or his family under this particular number. The OHIP number in question was [REDACTED]. Our source found an irregularity in this OHIP number as it appeared to be the number of the claimant's wife. There was some confusion to begin with as the OHIP number seemed to be in the name of a man, but we later unscrambled this and satisfied ourselves that the record in fact was under the name of [REDACTED] born in November of 1909, and the wife of your client, [REDACTED] or [REDACTED].

Our source indicated that the OHIP records had been "purged" as of the date September 1972. For this reason, the record of benefits or treatment under this particular OHIP number prior to this date were not immediately available. Our source did offer to make a search for the record prior to this date, but this may take several days to

obtain. We will forward this information on to you as soon as we receive it.

From what information that was available, it would seem that the claimant's wife, , has been getting frequent and regular treatment in the form of doctor's visits, diagnostic and laboratory tests and neurological examinations. The coding on this particular OHIP record would seem to indicate that testing was concentrated in the area of diagnosing or treating and urological disorder. This would cover such things as disorder of the kidneys, renal malfunctions, diseases or disorders of the urinary tract, calcification as in the case of kidney stones, etc.

The exact condition is not specified because of the general coding of records of this type. The record is reduced to a film record, hence the use of codes for the disorder, treatment or diagnostic procedures.

With regard to the claimant, , the record shows that he had x-rays taken on December 29th, 1972 and the coding indicates only that the x-rays were done by a clinic or general group called Diagnostic Radiology. This may be the name of a clinic or it may be only the general coding for the type of service performed. On the same date, December 29th, 1972, there is a record that the claimant, , had an office visit with his general practitioner, who is identified as Dr. J. The fact that he had a doctor's visit and x-rays on the same date might indicate that he was complaining of flu or bronchial disorders although this is not specified by the code.

On February 19th, 1973, had a general assessment examination, and this was in the order of a routine annual physical.

On April 18th, 1973, he had treatment by an orthopedic specialist and the coding for his condition would indicate an arthritic or gout condition.

This is the extent of information available from his record covering treatments and benefits eligible under _____'s OHIP coverage.

As mentioned above, our source will check further into this record to see what treatments or ailments are recorded prior to September 1972, specifically to cover the period back to 1968. Source will also attempt to determine if this is a self-paid coverage or if he is covered under a group and if so, he will identify the employer. It is possible that the claimant's wife may have had coverage if she was ever employed. He will also attempt to find out if this particular OHIP coverage is in any way connected with Welfare or any other public assistance agency. As indicated, we anticipate a delay of several days, but we will get you the information as soon as possible.

We must caution you about the use of this information so that its source is not identified. We understand that our last conversation with Mr. MacPherson on September 20th, 1973 confirmed that this will not present any problems to you.

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ADDENDUM:

Further to our several telephone conversations with your office, this is to confirm that we have finally received word on our inquiries through the Police Department, the Metro Toronto Welfare Department and OHIP.

Claimant does not have a police record.

Welfare sources report no record of any payments ever paid to your claimant. This does not exclude the possibility that he may be receiving benefits under the Provincial Welfare system. We are unfortunately, unable to confirm or obtain any information through the Provincial Welfare scheme.

OHIP reports back that they have checked all the way back to the commencement of the current OHIP plan, which was April 1, 1972. This search produced only two entries. One on August 24th, 1972 which was an office visit with an orthopedic specialist, apparently for a diagnostic evaluation. The other entry is for November 23rd, 1972 and this was for a lab test listed only under the general heading of micro-biology. This would be something in the order of a routine urine test. No other entries on his OHIP schedule.

A further check under the membership records of OHIP revealed that Mr. [REDACTED] is a Pay Direct subscriber.

Further checking revealed, however, that the claimant is receiving full premium assistance through OHIP. This means that he has satisfied OHIP that he had limited or no income. We are checking further to establish whether or not [REDACTED] is admitting any income.

This information is to be obtained through a different department at OHIP and we are advised there may be a delay of several days. We will continue to follow up and will advise you as soon as we have some information.

File No. 135

Confidential Source
Ontario Hospital Plan
Toronto, Ont.
Feb. 3/75

This source advised us that it would be necessary to run claimant's father's OHIP No. through the computer, [REDACTED], locate the file. This person indicated that this process would take some time and they would call us with the results, when they became available.

Later in the day, we heard from our confidential source at Ont. Hospital Plan, who advised that there had been three confinements here, the first one July 1/72 - July 9/72, then July 13-21/72 and finally March 28/73 - April 12/73. Our source advised that the total billings were slightly above the \$1,437.15 which had been reported earlier in our investigation, indicating that possibly only minor items had been added to the bill since that time. We point out here that our source has their own ideas as to the amount and type of information which can be provided. We learn that claimant's father, , is still covered under his old policy, , and there is an indication that the family was receiving Welfare assistance, either at the present time or fairly recently. They have in their records the address of Ave. Following this, apparently the family moved to in Mississauga, Ont. The number is recorded as , Mississauga, Ont. and finally the present address seems to be . We have had the source spell the name of the street to us, , Toronto, Apt. or Suite .

File No. 138

Checking with a confidential source with access to O.H.I.P. records we find that O.H.I.P. has a file on this claim, their file number being . Claimant's O.H.I.P. number is . O.H.I.P.'s total for expenses to this time is \$187.38.

Their records show that claimant attended at the Etobicoke General Hospital Emergency Department on January 25th, 1976. She was treated in the out-patient department and was not admitted to the hospital.

Records show that claimant had been attended by the following doctors:

A Doctor G, her attending physician apparently. He attended the claimant at his office on January 27th and February 5th and February 20th for a total billing of \$18.90.

Claimant was seen at the Etobicoke General out-patient department by a Doctor K on January 25th and his billing was \$5.13.

Claimant was attended by a Doctor J who is a diagnostic radiologist and he attended the claimant on January 27th and took x-rays.

A Doctor E a chiropractor attended the claimant on February 20th, 1976 and he had a billing of \$7.00 presumably for his first consultation visit with the claimant and he apparently then started her on a course of physiotherapy. There was a total of ten treatments at the Etobicoke Medical Centre from February 20th, 1976 to March 15th, 1976.

Claimant was then seen on April 27th by a Doctor K and his billing is for \$6.30. He also saw the claimant again on June 22nd, 1976 and at this time the rate had been increased and his billing for that visit is \$6.75.

A Doctor M saw the claimant on May 13th, 1976 and he is a diagnostic radiologist and took more x-rays. On the same date May 13th, 1976 claimant was examined by an orthopedic specialist a Doctor G and his billing is \$22.50.

All of these doctors with the exception of Doctor K at the Etobicoke General are thought to be practitioners at the Etobicoke Medical Centre on East Mall in Islington.

The O.H.I.P. record indicates a number of lab tests done on the claimant in conjunction with these various treatments, but O.H.I.P. does not charge for these lab tests as it is not practical to try and positively relate them to the treatment for accident injuries. These lab tests constitute only a very small amount of money, and as indicated O.H.I.P. does not treat these as being serious or necessary parts of the treatment of the claimant's injuries.

O.H.I.P. records show only the residence address of _____ Road and they have not been advised of any change of address.

File No. 139

From his O.H.I.P. reference number of _____ we learn that subject receives treatment at St. Joseph's Hospital and also through the West Toronto Physiotherapy, and the date of treatments started at the time of the accident, November 3rd, 1975, and the last treatment was December 2nd, 1975, totalling approximately one month.

His bill to O.H.I.P. was \$289.45 for these treatments. It is also noted that his doctors are Dr. S, and Dr. W.

File No. 141 (1)

We again contacted OHIP but they report that they have run into a number of problems in locating this file. Tracing one of the file numbers which they had previously given us, they found a different named OHIP subscriber. They are continuing to look into the matter and hopefully they will have it straightened out within the next week or so and they will notify us as soon as they do.

File No. 141 (2)

Checking with a confidential source at O.H.I.P. he reports that a file was opened with regard to a _____, relating to a claim for injuries in a motor vehicle accident on October 17th, 1975. _____ was represented by the law firm of Thomson, Spencer and Stewart at Box 53, Suite 2010, 401 Bay Street, Toronto. O.H.I.P.'s file number on this particular case is _____. The file was opened on December 23rd, 1975 and an O.H.I.P. number was advised for _____, that number being _____. There is also an attending physician listed Doctor B in Toronto. O.H.I.P. checked out the number given and the O.H.I.P. number indicated is not listed and they cannot match it with

anything in their file. There has been no information or reporting from Doctor B and in fact the file is limited to those basic details given above. There has been no activity on the file at all since it was opened in December 23rd, 1975.

However, reference is made to a previous accident involving this man , indicating that this prior accident happened in 1971 and the claim file at least as far as O.H.I.P. was concerned was closed in July, 1975. That file number was . There are no details given in the file with regard to this 1971 accident.

Our source has undertaken to make enquiries through Doctor B and also through the law firm to determine further details which might help identify as to residence and business connections. Also he hopes to have further details with regard to injuries and so on as O.H.I.P.'s interest may apply. He has also volunteered to request a printout if any still exists on the previous claim in 1971.

He has asked that we hold our file in abeyance for perhaps two weeks by which time he hopes to have at least some further details which would be of assistance to us.

File No. 142

Confidential Source,
Toronto, Ontario November 16th, 1977.

On this date we heard from a confidential source who advised that the total medical bill to this point was \$1,423.35, and apparently there was additional charges to come, they would be doing an up date on this account in the near future. The claimant apparently saw Dr. D, who is possibly the family Doctor, July 3rd, 1974, and x-rays were taken. Since that time there had been visits to a Dr. G, Dr. R, Dr. N and Dr. M. There were also visits to a Dr. B and a Dr. Ba, these two apparently are

psychiatrists. The last payment was made to a Dr. C, an orthopedic surgeon, September 9th, 1976. There apparently was a bill for a test for Glycoma, however this was not included, as it was thought it did not relate to the accident.

File No. 162

A confidential source with access to O.H.I.P. records supplied the following information.

The persons injured in this accident on November 11th, 1973, were , born March, 1949, male, and holder of the O.H.I.P. certificate. His wife, , born January, 1950, the female spouse of the holder and , born August, 1973, male, child and dependant son of the O.H.I.P. certificate holder that is .

Source confirms that their records show some confusion also and that the child is referred to in some of their correspondence, this apparently in error. The record in other places lists the infant only as boy .

However, the records do show that , born August, 1973, was admitted to the Etobicoke General Hospital on November 11, 1973 and discharged at 10:30 A.M. on November 15, 1973. His injuries are listed as a head injury, fracture of the skull. His Etobicoke General Hospital chart number was 7613, he was accommodated in the hospital at the standard ward rate of \$63.00 per day and he was in room 6084. He was admitted to the hospital through the emergency department and was brought to the hospital in an ambulance. His attending physician throughout is a Dr. D. The total amount of O.H.I.P. interest for the infant , was \$478.85. The O.H.I.P. interest for Mrs. was \$76.10, and for their total was \$52.55.

For , born March, 1949, they show an out patient assessment charge of \$13.50 was made for November 11th, 1973. Further records indicate treatment for the father on November 23rd, December 22nd, January 31, 1974 and a number of visits increasing steadily through the months of February and March, 1974. Attending physicians listed are a Dr. N, Dr. K, Dr. L (x-rays). From the information he had available, source could not identify any doctors who are Psychiatrists, but he would assume that the attending physician for the infant, Dr. D was a specialist in Neurology or Neuro-surgery.

The wife, , received emergency treatment at the Etobicoke General Hospital on November 11, 1973 and again on November 12, 1973. She was attended by a Dr. K on November 11th, attended by a Dr. T on November 12, 1973, and by a Dr. G.R. Turner on November 20th, 1973 and December 4th, 1973. Her injuries are not specified. She was not admitted to hospital.

Source confirms after a complete review of their file that , born March, 1949, was not admitted to hospital at any time from November 11th to the present time. They have no indication of any ongoing treatment for either , or his son, . Source confirmed that the O.H.I.P. bill has been and as far as they are concerned the case is closed with no further interests on O.H.I.P.'s part to recover any other expenses as a direct result of this accident.

The discharge of , on November 15th, 1973, was apparently to his home as there is no indication he was transferred to another hospital or to any other centre for examination, observation or further treatment.

is covered under the O.H.I.P. group operated by Ford. The Investigating Officer at the scene of the collision on November 11, 1973, was P.C.H. Archibald,

#3399 of #2 Traffic Division. The collision was apparently a head collision, and source confirms the other driver was your assured. We had been unable to identify any doctor in the Toronto phone book by the name of Temorack or Tamarack, but our source offered to check reference books available to him which might identify this Psychiatrist for us and he will advise.

File No. 183

In the meantime we had also contacted the O.H.I.P. people to try and ascertain a new address for the subject and also try and obtain some information regarding the subject's file with them and as far as they were concerned the file is closed, no recovery obtained, they only had the address of for the subject, their file number. They had several treatments for physiotherapy and also for psychotherapy, according to their file the total payout was \$195.40. The results indicate that he saw Doctor C, Dr. T.

File No. 184

On the afternoon of Wednesday, May 5th we contacted a source at O.H.I.P. We requested a search of the O.H.I.P. records in connection with , St., provided our source with the O.H.I.P. No. specifically requesting information regarding this man's experience with Dr. W in an attempt to determine if this Doctor could be considered the family physician as indicated.

On Monday, May 17th, we received a reply from our source at the O.H.I.P.

This source advised that he had located a file on , was not inclined to locate any files on or .

He indicated that had been attending the Medical Group since at least Nov. of 1974, however, had not seen Dr. W

for any medical attention prior to the accident Nov. 30th, 1975. He seemed familiar with the Medical Group, was familiar with the head of it, a Dr. C, and indicated that the pattern at this Medical Centre was, that the patients would be assigned to whatever Doctor was available at any particular time.

File No. 190

Recently we have heard back from both the Unemployment Insurance Commission and OHIP.

My sources at UIC were unable to gain any further information in regard to claims through the Fund by Mrs. .

Under OHIP, File No. , the total which this agency is looking to recover, as of June, 1976, is \$3,631.23. Only one claim under the OHIP number as previously presented (one individual) and claimant was born 1932.

In January, 1974, Mrs. consulted a doctor B a general surgeon at [address] - seen for surgery consultation.

In February, on the 11th, 1974, office visit with Dr. T, for symptoms for cold, flu etc.

May 9, 1974 saw Dr. L, specialist in internal medicine at [address], Toronto. On that date had an E.C.G. and a whole series of lab tests - R.B.C., W.B.C., (an annual review). Also on May 9, 1974 she had an x-ray of the spine but the doctor's name could not specifically be ascertained.

I might add here that OHIP will only go back six months prior to the date of the loss - further background checking will not be done unless they are present with a subpoena - this being a new regulation.

That is the extent of information prior to the date of loss which is available, to us.

We checked with OHIP and they report a file open with regard to this claim and their file number is . However, their file shows only bills incurred up to April 1977 and their total interest is listed at \$62.95 up to the present time. They show injuries as whiplash with cervical strain to the shoulder, neck, arms, back and legs. There is no record of any hospitalization although she was x-rayed. X-rays were done on the 25th of January and the total for that service was \$36.90.

The one useful piece of information from OHIP's file however was to identify a physiotherapist who had supplied treatment for Mrs. . Their record showed one treatment only, however, and this on the 28th of January, 1977 for a total bill for physio of \$5.80. The therapist is identified as a Mr. C, at [address]. They also show visits to the claimant's doctor, Dr. I of [address], visits to his office being on January 25th, 1977, March 7th, 1977 and April 29th, 1977. Our source at OHIP offered to update the file and to be in touch with us in a week or so if there was any additional information.

We spoke with a source at the office of Mr. C, who confirms that Mrs. started treatments on January the 28th, 1977, and had one treatment at that time and the treatment was for acute neck strain as a result of a motor vehicle accident on January 24th, 1977. They did not hear from Mrs. again until March the 14th, 1977 when she commenced a programme of treatments, some 15 in all, which were concluded by April 26th, 1977. She again returned for additional treatment of therapy on June the 2nd, and had a treatment on that date and also June 23rd, 24th, 28th, 29th, and 30th, and on July 5th, 7th, 12th, 13th, 14th, 20th, 21st, 1977.

We contacted Mr. C's office on July 21st, 1977 and our source there indicated Mrs. had been in earlier that morning. They checked the appointment list for Friday, July 22nd, 1977 but Mrs. was not scheduled for an appointment on that date and apparently she had indicated she will consult again with her doctor, Dr. I, before continuing with the two remaining treatments out of the 15 scheduled.

This source at Mr. C's office confirmed that all of these treatments related to one motor vehicle accident only on January 24th, 1977 and if there were any subsequent accidents this office has not been advised.

We contacted Dr. Irvine's office, but they would not discuss Mrs. 's case without a written authorization from the claimant.

File No. 201

We have just heard from our confidential source that Mrs. was admitted to Centenary Hospital in Scarboro on May 25th, 1977 and she was admitted and confined to the hospital until June 3rd, 1977. Her admitting diagnosis is listed as a possible pulmonary embolism. This source reports that the injury is consistent with traumac bruising of the chest and stomach area and would be likely if the victim was thrown violently against the steering wheel of a car. Source reports that they are considering this as a possible related injury to the accident. The per day rate at Scarboro Centenary Hospital is \$110.75, although this may have been adjusted upwards most recently.

Mr. White testified that he believed that every OHIP employee had an obligation to keep information which came to him or her in the course of his or her employment, confidential, except such persons as Mr. Gordon who were involved in the operation of OHIP's subrogation department. His testimony, in relation to Mr. Gordon, may be briefly summarized, as follows:

1. Mr. Gordon was employed by OHIP in its subrogation department.
2. The subrogation department, like any other insurance company, was involved and interested in claims settlement.
3. As the subrogation department was like any other insurance company, employees involved with subrogation would provide information verifying the medical aspect of claims to others interested in insurance claims.
4. The subrogation department in providing this information, was co-operating with the insurance industry and acting within The Health Insurance Act, 1972, which governed OHIP's activities.
5. Mr. Gordon in providing this information was therefore doing his job and there was nothing improper in Mr. White's seeking out this information.
6. Any other investigator would be as able as he was to obtain this type of information from Mr. Gordon and others in the subrogation department.
7. Although any other investigator could obtain this information from Mr. Gordon, he was, according to an internal arrangement at C.C.R. and Retail Credit Company of Canada Ltd., the sole person permitted to contact Mr. Gordon and all inquiries of OHIP were to be channelled through him.

One of my purposes in setting out the OHIP information obtained by Mr. White in detail was to show that the tone and content of the reports are inconsistent with Mr. White's professed beliefs. The repeated use of the phrase "confidential source" and the words "We must caution you about the use of this information so that the source is not identified" are irreconcilable with an honest belief on Mr. White's part that Mr. Gordon was acting properly and within the scope of his employment in releasing the information. It was Mr. White's opinion that "the whole basis of the insurance investigation

business...[is] to gather information which is not readily available...." It is inconceivable to me that insurance companies, which are the most sophisticated of institutions, would pay Mr. White to obtain information in the belief that it came from a "confidential" source if they were able to obtain this information by an open and direct request to OHIP.

It is noteworthy that Mr. Wright, the president of W.A. King Ltd., was unaware of the internal arrangement at C.C.R. whereby Mr. White was the sole person at C.C.R. permitted to contact Mr. Gordon. Mr. Wright only knew that Mr. White had a "confidential source" at OHIP. I conclude that this internal arrangement was an informal one, fashioned of necessity between the other investigators at C.C.R. and Mr. White because, unlike Mr. White, they were personally unable to obtain information from OHIP. If the other investigators had been able to obtain this information, they would surely have done so. I am of the view that the statements of Mr. White which I have set out above are not an honest expression of his belief and that at the time he obtained OHIP information from Mr. Gordon he knew that this information ought not to have been released to him. In his mind, Mr. Gordon was truly his confidential source.

Elsewhere in this report there will be found a detailed description of the way in which OHIP works and the manner in which information is received and maintained by OHIP. But in order to explain the relationship between Mr. White and Mr. Gordon, it is necessary to give an elementary account of the OHIP system as it related to the subrogation department at the time of the events discussed in this chapter and throughout the period of our hearings. A new arrangement, to be described later, has very recently come into existence. The subrogation procedure relating to automobile accidents has been drastically modified although the legislation does not yet reflect the change and, at the time this is written, still contemplates the procedure now replaced by the new arrangement. (See section 36(1) of The Health Insurance Act, 1972, S.O. 1972, chapter 91.) But at all material times the subrogation system I am about to describe was in place with respect to claims arising out of motor vehicle accidents. For that reason, and because that system continues to have application for subrogated claims arising otherwise than as a result of automobile accidents, I run the risk of inaccuracy and use the present tense.

The Ontario Health Insurance Plan, in its present form, was created by The Health Insurance Act, 1972 and provides insurance against the cost of certain "insured services" which are defined in the Act as:

...services of hospitals and health facilities as are prescribed by the regulations, all services rendered by physicians that are medically necessary and such other health care services as are rendered by such practitioners and under such conditions and limitations as are prescribed by the regulations...

Where, as a result of negligence or other wrongful act or omission of another person, a subscriber of OHIP suffers personal injury for which he receives insured services, OHIP is subrogated to the right of the subscriber to recover the cost of the services received and to be received as a result of the negligence, wrongful act or omission. A subrogation department was therefore established by OHIP. Employees in the subrogation department are persons experienced in the examination of claims. Their function is to:

- (a) establish what services were required and costs incurred as a result of the negligence or wrongful act or omission;
- (b) make inquiries as to liability, that is, to determine whether or not the subscriber was totally or partially responsible for the loss because this contributory negligence would reduce or prohibit OHIP's recovery; and
- (c) determine the costs of future medical care.

Liability insurers have an obligation to notify OHIP of any negotiation of any loss or negotiation for settlement of any claim for damages which includes a claim for insured services. OHIP also learns of its right of subrogation from police accident reports on film forwarded by the Ministry of Transportation and Communications, from the subscriber or his or her solicitor (who has an obligation to inform OHIP forthwith after the issuance of a writ of summons claiming damages), from hospital forms and from physiotherapists' forms. Practically speaking, there was always a race to determine who would first notify OHIP of the loss as between the liability insurer and the subscriber's solicitor because, as a matter of policy, OHIP dealt directly with the liability insurer, if the liability insurer notified OHIP of the loss before the subscriber's solicitor did. If the subscriber's solicitor notified OHIP first, OHIP retained the solicitor to act on its behalf and did not deal directly

with the liability insurer. This is significant because the solicitor would thereby be entitled to charge a prescribed fee to OHIP and the insurer would be obliged to pay party and party costs of the litigation to the subscriber which would reflect OHIP's claim. Party and party costs would not be paid if the liability insurer were able to deal directly with OHIP.

OHIP maintains relevant medical claims information on the claims reference file which consists of a number of computer tapes. The contents of this claims reference file are reproduced monthly on microfiche, which is a film negative, approximately six inches by four inches containing 208 computer pages of OHIP information in reduced form. Approximately 7,000 sheets of microfiche comprise the monthly output of the claims reference file. Individual microfiche may be inserted into a viewer and the information contained on the negative is enlarged to readable size. By pushing a button on a special print viewer, a paper reproduction of what is seen on the viewer is produced. "Claims fiche" or "medical fiche" as the claims reference file output on microfiche is called, is produced monthly and contains all diagnostic and treatment information provided to the Ontario Health Insurance Plan with respect to insured services.

Every physician in the Province has been assigned a number as has each hospital. There are also diagnostic codes and fee schedule codes. With possession of the code books, which are readily available at every OHIP office, one is able, from the claims fiche, to determine information under the following categories for every service performed:

- (1) clinic number, if there is a clinic number;
- (2) practitioner's number;
- (3) the practitioner's speciality code;
- (4) physician's accounting;
- (5) whether it was a referral;
- (6) the number of the clerk who did the assessment;
- (7) the date on which the assessment was done;
- (8) the claim number for each service;
- (9) the item number;
- (10) the hospital admission date if there was a hospital admission;
- (11) the diagnostic code;
- (12) the fee schedule code;
- (13) the date on which the service was performed;

- (14) the number of services performed; and
- (15) the fees billed, approved and paid.

Every family usually has one number. Therefore, all services rendered to any given family are grouped together on the claims fiche.

OHIP also produces, (1) an alpha microfiche which is an alphabetic listing of all pay direct subscribers and group subscribers showing, for the pay direct subscribers, their home address, and for the group subscribers, the name and address of the employer, and (2) enrolment microfiche, which is a numeric listing of all subscribers in which the enrolment data are keyed to the OHIP numbers.

Once OHIP determines that a subrogated claim is to be made, the computer does a data run from the claims reference file which results in a print-out of particulars of services rendered to the subscriber since the date of the accident. Clerks employed in the subrogation department transfer and translate the coded information to handwritten summaries which set out only the date the service was rendered, the name of the physician providing the service or the hospital at which the service was performed and the amount of the fee paid. There is neither diagnostic information nor fee code information provided in the summary.

In the transfer from print-out to handwritten summary, the clerks attempt to delete particulars of any services which are not traumatic in origin. For example, if a person who suffered a broken leg in a motor vehicle collision later visited a physician for a sinus infection unrelated to the subrogation claim, particulars of the service rendered on that visit would be itemized on the print-out. The fee paid for this attendance would not be a proper item of subrogation and the clerk would not include this item in the handwritten summary. The handwritten summary is forwarded to the liability insurer or the subscriber's solicitor, as the case may be, and is the document upon which the subrogation claim is based. Updated subrogation summaries are usually provided every five months, or, on request, by claims examiners at OHIP who have carriage of the matter; for example, when a claim is ready for settlement, a specific request for an updated summary is usually made.

The claims adjusters are assigned claims, as they are taken in, on a rotating basis. Generally, each subrogated claim is contained in a separate file. However, if a subscriber is involved in consecutive accidents, it is possible that the information for both accidents may be contained in one file.

At the time of our hearings, Richard Godden was an experienced claims examiner. He had been involved in the insurance industry since 1943. He was first employed with the Ontario Hospital Services Commission in 1965 as a claims adjuster. In 1972, at the time of OHIP's creation, he moved to OHIP's subrogation department and has worked full time in the subrogation department ever since.

I found Mr. Godden to be knowledgeable, frank and conscientious. His practice, in subrogation matters, was to deal only with adjusters or solicitors and not to provide any information to an investigator because, in his view, an investigator had no authority to settle a claim. There were, to his mind, two possible ways of analyzing an investigator's involvement with a subrogated claim. If OHIP had retained a solicitor to deal with its subrogated interest, the investigator should have sought information from the solicitor. If OHIP dealt directly with a liability insurer, the liability insurer or the adjuster retained by the liability insurer would receive all necessary information and the intervention of an investigator was unnecessary. He therefore exercised extreme caution in dealing with investigators since he believed investigators attempted to get information that their principals did not have. This very common-sense approach, and his experience, caused him to form the opinion that:

There would be only one purpose in an investigator calling and that would be to get information that was more than what I provided, which they are not entitled to. Therefore, I have no need to talk to them.

Mr. Godden had no recollection of an investigator contacting him to request confirmation of an OHIP number. Indeed he could not understand why such verification would be needed since only OHIP had any use for this number. He had never been requested to, nor had he ever provided, information as to whether a subscriber was a pay-direct subscriber and if so, his or her home address, or if the subscriber was a member of a group, the employer's address. In fact, Mr. Godden did not know how that information could be obtained from OHIP's records. Mr. Godden never released to anyone, let alone an investigator, a subscriber's past medical history. He had never translated a diagnostic code for an investigator, or anyone else, into a diagnosis although attempts had been made to obtain that sort of information from him.

One of the exhibits filed at our hearings was an Equifax Services Ltd. file containing information that clearly came from

an OHIP subrogation file managed by Mr. Godden. Mr. Godden was named in the Equifax Services Ltd. report as the source of information. Mr. Godden handled between 50 and 100 files per day and, quite understandably, had no recollection of this file. I do not know how this information was extracted from OHIP. I am certain, however, that if Mr. Godden provided this information, it was out of the ordinary and, in fact, an isolated instance. I do not attribute any wrongdoing or attach any blame to Mr. Godden in respect of the release of that information. It is possible, that Mr. Godden may, on this one occasion, have failed to follow his usual careful practice. It is also quite possible, even probable, that the information was extracted by pretext. I make no finding on either of these possibilities but repeat that it is my opinion that Mr. Godden is an extremely competent and careful employee who is diligent in the execution of his duties. No criticism of him of any kind is warranted.

Brian Dew Carter is employed by OHIP as a claims examiner. He was first employed with the Ontario Hospital Services Commission and, in 1972, with the creation of OHIP, he joined OHIP's subrogation department and has worked full time in the subrogation department ever since. Mr. Carter's practices with relation to investigators were somewhat different from those of Mr. Godden. From time to time, Mr. Carter entered into discussions with investigators. He did so because he believed that he could learn of motor vehicle collisions in which subscribers were injured but which had not been reported to OHIP. From about 1976 he had discussions with Robert Britnell, an employee of Equifax Services Ltd., who, on occasion, advised him of collisions and provided particulars of names and OHIP numbers of subscribers who had been injured but who had given no notification to OHIP.

Mr. Carter agreed with Mr. Godden's opinion that the seeking of an OHIP number by an investigator must be regarded as suspicious:

MR. COMMISSIONER: ...the question is if you agree that you can think of no reason why an investigator would want the OHIP number, if the investigator asked you for the OHIP number in a situation where he didn't have it, the fact of his asking must be suspicious?

A. In that vein, in my job, it would be suspicious.

There was evidence that, on one occasion, Mr. Carter provided Mr. Britnell with an OHIP number and the contents of a summary. Mr. Carter testified, and I accept his evidence, that he did so on this isolated occasion because on the very morning of Mr. Britnell's call the handwritten summary had been mailed to Mr. Britnell's principal. Mr. Carter stated that this was the only occasion on which he ever provided any investigator with the contents of the handwritten summary:

MR. STROSBERG: Mr. Britnell, as I understand his evidence, says there was more than one occasion on which he was able to obtain OHIP numbers?

A. That may have been his evidence sir, but I don't recall now ever having given it to him on more than that, other than that one particular occasion.

I accept Mr. Carter's evidence on this point. Mr. Carter and Mr. Godden handled many files on a daily basis. This release of the contents of the OHIP number and of the handwritten summary to Mr. Britnell was an isolated event. I attach no culpability or blame to Mr. Carter in respect of it.

Mr. Carter was adamant and definite in his evidence that he never released information about any subscriber's prior medical history to any investigator, or in fact, to anyone except a subscriber's solicitor. He confirmed Mr. Godden's evidence that he had access to that information but added that he would have to make a specific request before prior health history was delivered to him. Mr. Strosberg read Mr. Carter an extract from a report that formed part of an exhibit at our hearings. The extract was as follows:

Q. "Our source has access to confidential O.H.I.P. records and with the claimant's O.H.I.P. number he obtained a printout of benefits paid to [redacted] and/or his family under this particular number. The O.H.I.P. number is [redacted]. Our source found an irregularity in this O.H.I.P. number and it appeared to be the number of the claimant's wife. There was some confusion to begin with, as the O.H.I.P. number seemed to be in the same name of a man, [redacted], but we later unscrambled this and satisfied ourselves that the record in fact was under the name of [redacted] or [redacted], the wife of your

claimant, . Our source indicated that the O.H.I.P. records had been purged as of the date September, 1972. For this reason, the record of benefits or treatment under this particular O.H.I.P. number prior to this date were not immediately available. Our source did offer to make a search for the record prior to this date, but this may take several days to obtain. We will forward this information on to you as soon as we receive it. From what information that was available, it would seem that the claimant's wife has been getting frequent and regular treatments in the form of doctors visits, diagnostic and laboratory tests, neurological examinations. The coding on this particular O.H.I.P. record would seem to indicate that the testing was concentrated in the area of diagnosing or treating and urological disorder. This would cover such things as disorders of the kidneys, renal malfunctions, diseases or disorders of the urinary tract, calcification as in the case of kidney stones, etc. The exact condition is not specified because of the general coding of records of this type. The record is reduced to a film record, hence the use of codes for the disorder, treatment or diagnostic procedures. With regard to the claimant," (now that's the person's wife but would be under the same grouping and information). "With regard to the claimant, the record shows that he had x-rays taken on December 29, 1972 and the coding indicates only that x-rays were done by a clinic or general group called, . This may be the name of a clinic or it may be only the general coding for the type of service performed. On the same date, December 29, 1972, there is a record that the claimant, , had an office visit with his general practitioner, who is identified as Doctor J. The fact that he had a doctor's visit and x-rays on the same date may indicate that he was complaining of flu or bronchial disorders, although this is not specified by the code. On February 19, 1973, had a general assessment examination and this was in the

order of a routine annual physical. On April 18, 1973, he had a treatment by an orthopaedic specialist and the coding for his condition would indicate an arthritic or gout condition. This is the extent of information available from his record covering treatment and benefits eligible under [redacted]'s O.H.I.P. coverage. As mentioned above, our source will check further into this record to see what treatments or ailments are reported prior to September, 1972, specifically to cover the period back to 1968. Source will also attempt to determine if this is a self paid coverage, or if he is covered under a group. If so, he will identify the employer. It is possible that the claimant's wife may have had the coverage if she was ever employed. He will also attempt to find out if this particular O.H.I.P. coverage is in any way connected with welfare or any other public assistance agency."

This information was not read to Mr. Carter with the suggestion that he had released the information but rather to determine whether the release of that information might be justified in some way as necessary to the subrogation process and also to determine what his opinion was about its release. Mr. Carter was unaware of any person working in subrogation who would pass this information or information similar to this to an investigator or adjuster or any other person. He could not explain why the release of this information was necessary to the subrogation process. He said that this was not the type of information that he would expect to be given out and that he "would be appalled by it".

Charles Gordon is experienced in casualty claims adjustment, having had an extensive background in the private insurance industry prior to his employment in 1967 by the Ontario Hospital Services Commission. In 1972, with the creation of OHIP, Mr. Gordon became its subrogation liaison officer. A summary of his duties and responsibilities are set out in the job specification as follows:

1. As a Subrogation Specialist for the Section, reviews upon manager's request, procedural techniques within the section, and recommending revisions to improve the level of co-operation with

Medical and Legal professions, and insurance industry. Advises manager of amendments to various acts, regulations, and specific workings on insurance contracts, etc., and outlining implications of such changes on present and future subrogation activities. Advises Senior Adjusters re: activities on complex or unusual files where future insured services are anticipated, and where such settlements are in excess of their assigned authority. Upon manager's request, analyses such files, recommends subrogations procedures, and if necessary, concludes files to settlement. Calculates on an actuarial basis the potential or anticipated future insured services amounts for presentation in court or in settlement negotiations. Participates in in-chamber discussions with judges and representatives of both plaintiffs and defendants for pre-trial settlement negotiations. Negotiates Plan's total recovery potential, subject to amount of money available, apportionment of liability and probability of future insured services based on medical evidence. Attends court, giving evidence on details of past and future insured services, explaining details of procedures of total plan, elements, and extent of medical insured and non-insured services, drugs, and extended care services.

2. Maintains liaison with outside bodies and agencies encouraging close co-operation with medical and legal professions and insurance industry. Advising lawyers not familiar with litigation in procedures and point of law inherent in subrogation matters.
3. Lectures, as requested, at various Legal, Medical and Insurance Association functions on procedural Subrogation technicalities; other duties as assigned.

In February, 1973, Mr. Gordon took his oath of office and secrecy in the following terms:

I, CHARLES ALEXANDER GORDON, do swear that I will faithfully discharge my duties as a civil servant and will observe and comply with the laws of Canada and Ontario, and, except as I may be legally required, I will not disclose or give to any person any information or document that comes to my knowledge or possession by reason of my being a civil servant. So help me God.

In his position as subrogation liaison officer, Mr. Gordon was, in effect, the senior adjuster in the subrogation department and, through two more junior adjusters who were each allocated a group of adjusters, he was, for practical purposes, the supervising adjuster with the right (and sometimes the obligation) to review any file within the subrogation department.

Mr. Gordon became acquainted with Mr. White in about 1973. At first, he believed that Mr. White was an adjuster but by 1974 he knew that he was an investigator. In his testimony Mr. Gordon clearly acknowledged that all information set out in the C.C.R. reports attributed to a confidential source at OHIP had been provided by him to Mr. White except for certain portions which I shall mention later.

Simply put, Mr. Gordon's position was that the release to Mr. White of this information from OHIP's records was perfectly proper, having been done in the ordinary execution of his duties. It was excluded from the general obligation of confidentiality imposed by section 44(1) of The Health Insurance Act, 1972 which states that:

...each person engaged in the administration of this Act and the regulation shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment or duties pertaining to insured persons and any insured services rendered and the payments made therefor, and shall not communicate any such matters to any other person except as otherwise provided in this Act.

Mr. Gordon said that his treatment of Mr. White was no different from the treatment he would have accorded any other

investigator. He simply had not been contacted by any other investigator. There had been produced in evidence an investigation file seized early on our hearings from Centurion Investigation Ltd. That company had been retained to carry out an investigation as a result of a motor vehicle collision on April 24, 1977. Wayne Stewart, a licensed private investigator employed by Centurion Investigation Ltd., had been assigned this matter. He contacted OHIP and spoke to Mr. Gordon. There was a handwritten memorandum in the Centurion Investigation Ltd. file which read as follows:

Contacted Mr. Gordon, OHIP, re information on subject. He stated that he was not able to release any information if they have it because of Sec. 44 of the Health Insurance Act.

He stated that there is nothing that he can do because he and all civil servants are bound by the Act dealing with disclosure of information and suggested that the information required should be obtained from the Plaintiff's lawyers.

He stated that he regretted that he could be of no assistance but has no choice in the matter.

Mr. Stewart testified that he recalled speaking to Mr. Gordon and that he had prepared the memorandum which accurately reflected their discussion. Mr. Gordon accepted the fact that the conversation had taken place although he had no recollection of it. I have no doubt that this conversation took place. The handwritten memorandum is a record, made in September of 1977, of a failure to obtain information at the time, a full year before Mr. Gordon gave evidence and before the creation of this inquiry. Moreover, the memorandum has been in our possession since April, 1978. It did not become relevant until the summer of 1978 when we learned of the involvement of C.C.R. with OHIP. The authenticity of this memorandum is beyond question and is strong evidence of the invalidity of the proposition that the release of OHIP information to Mr. White was encompassed by Mr. Gordon's ordinary duties and, of his assertion, that section 44(1) did not apply. If Mr. Gordon had honestly held such a view there would have been no reason for him to refuse to provide information to Mr. Stewart.

Furthermore, there can be no rational explanation for the release of some of the information disclosed. For example, a

subscriber was involved in a motor vehicle collision and, in accordance with the usual procedure, a handwritten summary was prepared. The handwritten summary did not contain particulars of a visit to a physician when a test for glaucoma was carried out. However, the computer print-out contained in the subrogation file did show this test. There was a handwritten "X" next to the text in the computer print-out denoting that the information was not included in the handwritten summary. Mr. Gordon gave Mr. White particulars of the attendances set out in the handwritten summary and, in addition, particulars of this glaucoma test. There is no explanation, consistent with due execution of duty, for Mr. Gordon's act of providing Mr. White with this information. OHIP had already decided that this service was not a result of the motor vehicle collision and no claim for subrogation was being advanced in respect of it. Unable to explain his conduct, Mr. Gordon said,

Maybe I just talk too much when I speak to somebody on the telephone.

Several of Mr. White's reports contained the observation that a subscriber was in receipt of premium assistance. Here is one example:

ADDENDUM

Further to our report to your attention dated September 21st, 1973, and further to our telephone conversation with Miss Saracini of your office of last week, we enclose herewith additional information received from one of our confidential sources.

As you may recall, we had requested information through one of our sources with access to confidential O.H.I.P. records, specifically with regard to checking eligibility for OHIP coverage without having to pay premiums.

Our source reports that the only information available on this subject indicates that Mr. [redacted] applied for full family coverage under the OHIP provision which allows residents of Ontario to have free OHIP coverage based on a low income qualification. In Mr. [redacted]'s application to the OHIP Commission, he declared an income for the year 1972 of \$2,982.13. He was asked to

provide an estimate of his 1973 income, but said that he could not. Our source suggests that the income figure of \$2,982.13 is most likely _____'s income after taxable deductions. This would be suggested by the exact amount given by him rather than an estimate rounded out in even thousands. Source here pointed out that a total income before taxes of up to \$3,400.00 is allowed and any such application showing this income would be eligible for the free OHIP benefits.

Mr. _____'s application form signed in January 1973 gave his employment as "Unemployed". His occupation he listed as "former carpenter".

Our source here explained again that no proof of income is required from these applicants so that the figure given for income is not substantiated by T-4 slips or any other documentation. The whole system is based on the honour system and source admits that they have many people abusing this privilege. As a carpenter, he could have sizable tax deductions for tools, material, work clothes, etc. No facts or figures, however, are available on this. Mr. _____ indicated that his wife was not employed.

In our conversation with Miss Saracini, discussing the above information, we were advised that this case is now closed and that settlement has been made. For this reason, we will not pursue this matter further, but if we can be of any assistance to you in the future, please feel free to contact us.

Please add this to your file on _____.

There can be no possible justification, and Mr. Gordon did not attempt to give one, for the release of information disclosing that a subscriber was receiving subsidized OHIP coverage. This information could not possibly affect OHIP's right of subrogation and is irrelevant to a third party insurer. At first Mr. Gordon denied that he had provided this information though he conceded that some of the information in the report

had come from him. Later he admitted that it was probable that he had provided the information. I have no doubt that Mr. Gordon gave Mr. White this information. Mr. White candidly admitted that he received it from Mr. Gordon. Moreover, there was a handwritten message in the OHIP file, in these words:

From Mr. Whyte [White]
[Name]
[O.H.I.P. number]
Welfare or what?

A second slip, in Mr. Gordon's handwriting, says:

Shirley, call White
[telephone number]
When membership comes in find out his
group.

There were two other files containing information to the effect that subscribers were on welfare or subsidized. One report read, in part, as follows:

Later in the day we heard from our confidential source at OHIP who advised that the OHIP number we had provided for came out in the print-out as an invalid number. No explanation was available for this. The number was the OHIP number for . The number indicated that he had been on relief from November of 1975 until August of 1976. Apparently the payments had been picked up privately. There was no home or business address.

This report was prepared by Mr. Mangoff who testified that he had obtained this OHIP information from Mr. White. Mr. White said that he had received this information from Mr. Gordon. Mr. Gordon acknowledged that this information was available to him, but he denied that he had given it to Mr. White. He went on to say that there would have been no justification or reason to release this information. I prefer Mr. White's evidence to that of Mr. Gordon. I am satisfied that Mr. White obtained the information from Mr. Gordon and agree with Mr. Gordon that there was no justification for its release. Indeed, there can be no justification for conduct of that kind.

By his own admission, Mr. Gordon released particulars of treatments received by a wife of a claimant for a kidney problem. Mr. Gordon said that he might have released this

information inadvertently. I cannot think of any reason for the release of information of this sort. It is difficult to understand how the substantial information set out in File 134 could be released in a general conversation about OHIP's subrogated interests which did not include the amounts expended for these services. Mr. Gordon must have entered into a general discussion with Mr. White of the entire contents of this OHIP file without regard to his general obligation of confidentiality. Mr. Gordon termed the release of this information unfortunate. That was an understatement.

There were several occasions on which Mr. Gordon provided information about the previous health history of a subscriber to Mr. White. One of them is reflected in the following extract from one of Mr. White's reports:

ADDENDUM

May 28, 1974

Since completing our report, we have just heard back from our confidential source with information obtained from O.H.I.P. records on claimant .

O.H.I.P.'s file number is . The total amount outstanding and to be collected by O.H.I.P. is \$1,308.80 for hospital accommodation, care and treatment of the claimant, , as a result of the accident on May 1, 1973.

He was admitted to Scarborough General Hospital on May 1, 1973, and detained and treated there as a patient until discharged on May 18, 1973. Claimant was discharged to his home.

Attending physicians are a Dr. G, Dr. O and a Dr. B, all of Scarborough General Hospital. Another doctor mentioned is a Dr. P.

Dr. O apparently continued to see the patient as an out-patient and the record shows visits to Dr. O on June 11, 1973 and August 1, 1973.

There is a listing for a visit by a General and Plastic Surgeon, not named, for a visit on July 30, 1973, apparently also at the

out-patient department of the Scarborough General Hospital. The bill for this surgeon's visit is \$13.50. There is no mention that this surgeon saw the patient in connection with cosmetic surgery for a scar on the claimant's face. Our source speculates that this visit by the General and Plastic Surgeon would probably have been to check on the surgical wound or scar left by the treatment for 's pelvic injury.

Injuries are listed as a fractured pelvis and concussion.

Claimant's date of birth is listed as May, 1960.

Claimant's parents are , employed as a printer with , Street, Toronto. Claimant's mother is no employment listed.

The only previous medical treatment listed on 's O.H.I.P. record is for a complete assessment and examination by an Otolaryngologist. This doctor is not named, but the visit was on November 13, 1972. This examination is usually done in cases where a youngster is complaining of repeated sore throats sinus trouble or possibly infected tonsils. Our source did agree, however, that the examination may have been done if the claimant had some difficulty with his ears which could produce dizzy spells or loss of equilibrium. There are not details of the patient's complaint, nor are there any indications of treatment, source emphasizing that this particular visit in November, 1972, was for an examination and assessment only.

There is no record of any previous treatment or any current treatment for cosmetic surgery in connection with the scarring on the chin.

The motor vehicle accident with which that extract was concerned took place on May 1, 1973. Mr. Gordon justified the release of the information about the prior examination by an

otolaryngologist on November 13, 1972, on the basis that the release of this information would expedite settlement. I cannot accept that explanation. A review of the total OHIP file indicates that this matter was being handled in a reasonable fashion by the subscriber's solicitors who had also been retained by OHIP. The Health Insurance Act, 1972 does not permit the release of that kind of information even if it might expedite settlement. There was, in fact, no justification for the disclosure of this information to Mr. White.

Another example of the revelation of prior health history by Mr. Gordon to Mr. White is seen in this extract from two investigation reports relating to the same investigation:

File No. 169 (1)

...Checking with a confidential source with access to O.H.I.P. records, he reports that they are aware of _____'s motor vehicle accident of April 27th, 1974. Their involvement thus far with regard to his injuries in this accident is in the amount of \$126.66. This was for out patient treatment at the Scarborough Centenary Hospital. His injuries are listed merely as bruising, the shoulder, elbow and ankle being indicated as injured parts. X-rays were taken on April 30th, 1974, at the same hospital. Doctors mentioned as having seen or treated are a Dr. B, a Dr. T and a Dr. W.

Also on his record is the following information regarding prior O.H.I.P. involvement in the health care of this man, _____.

_____ was hospitalized in January 13th, 1974, and was admitted until January 16th, 1974, for a varicose vein operation. The hospital is not identified.

Also on record is an office visit to the office of Dr. W who appears to be his family physician. The office visit was on April 26th, 1974, one day before the date of your accident. On that date in the office, lab tests, were done on Mr. _____, some fifteen in all.

These tests included the following: - Calcium, Cholesterol, Glucose, Colorimetric, Alkaline, SGOT, BUN Uric Acid, Blood Film, Differential Count, Reticulocyte, White Cell Count, Hematocrit, Sedimentation, L.E. Cells, and also a check for the Rheumatoid Factor.

There is nothing further on record to indicate any treatment that might have been done as a result of these tests.

Source could not comment on what effect this testing would have had on the claimant. He explained that although there were a large number of tests done for various factors, this could have been done with a small quantity of blood extracted from the patient. The amount of blood taken would not be sufficient to leave him weak, and should have been replaced within a 24 hour period which would take him in to the next day, the date of your accident. He did say, however, it was fairly safe to state that anyone with a circulatory problem in their legs, and especially anyone who has had varicose vein surgery would probably not have strong legs, and would therefore not be able to move as quickly or with the same control as someone with healthy, normal legs. The effect of the poor circulation on the muscle tone of the legs would be quite obvious, and would be more obvious in a man approaching 60 years of age.

From the casual observer's point of view, there probably would be little difference between the walk of a man with bad circulation or varicose vein problems and a man who might have had his legs injured in a work accident which had produced fractures or other leg damage.

We asked our source to check further to see if [redacted] is covered under O.H.I.P. through an employment group and if so to obtain the name of said group. Source agreed to do this but indicates it may take up to a week to get this checked out.

This is further to our report to you dated July 4th, 1975 and as promised in that report, we here enclose additional information obtained through a confidential source with access to O.H.I.P. records.

Source reports that claimant is covered for O.H.I.P. under his wife's plan, her O.H.I.P. group being listed as , Avenue, Scarborough.

The claimant has been covered under his wife's plan since 1968.

Source reports that the claimant in addition to the extensive laboratory testing done on April 26th, 1974 had a further and equally extensive examination done during May and June, 1974 including an ECG.

The O.H.I.P. record also shows that the claimant's wife also underwent extensive testing during the same period, May and June, 1974.

Source reports that claimant has a large number of entries on his file which would indicate that has obviously a health problem.

Mr. Gordon denied that all of the above recited information came from him but I believe that it did. Mr. Gordon admitted that he had provided the information about the pre-existing circulatory problem but postulated that he may have revealed this problem because Mr. White had suggested that OHIP would not be entitled to its complete subrogated recovery. I do not accept this as a reasonable possibility. Mr. Gordon did not provide the solicitors retained to recover OHIP's subrogated interest with this very same information, which is what he would have done if such a suggestion had been made. Mr. Gordon had no explanation for giving Mr. White information about the subscriber's wife, her employer, and about her having undergone extensive testing during the months of May and June of 1974, although she had not been injured in the collision and no subrogation claim was being asserted on her behalf. Mr. Gordon was unable to give any explanation because there can be no explanation that is consistent with the proper execution of his duties.

Sometimes Mr. Gordon gave Mr. White information from a closed file. A subscriber had been injured in an accident on April 13, 1974. OHIP dealt directly with the third party insurer, recovered its total subrogated interest and closed its file in May, 1976. There is a memorandum in the file confirming that Mr. Carter received a telephone call from this subscriber who expressed dissatisfaction with the fact that OHIP, in the ordinary course of business, had provided the insurer with the handwritten summary. The subscriber was upset because he interpreted the quite proper release of the handwritten summary as "nosing into his personal affairs." The total subrogated interest had been recovered and the OHIP subrogation file closed in May, 1976. In October, 1976, after the OHIP file had been closed, Mr. Gordon, as he admitted, provided information to Mr. White. Mr. White's reports, reciting this information, read, in part, as follows:

From confidential sources we learn the following:

Claimant's O.H.I.P. number is . His group number is , which is the O.H.I.P. group number. O.H.I.P.'s file number is and his file had been closed as of May, 1976, but maybe reactivated due to recent billings.

Of interest was a notation in the file to the effect that Mr. had complained to O.H.I.P. about the release of information on his O.H.I.P. charges claiming that this was an invasion of privacy. The information was released by O.H.I.P. to your company as part of their claim for recovery of expenses.

had requested O.H.I.P. to release no further information to the third party company and that any requests for information by your company through O.H.I.P. should be referred to his lawyer a Mr. Stanley Kotick. This complaint from had apparently come into O.H.I.P. by telephone sometime in 1975.

Claimant's injuries are listed as being a whiplash type injury with cervical strain, listed as chronic strain of T3 and 4 and L4 and 5. As of October, 1974 O.H.I.P.'s total for recoverable expenses was \$122.81. The first date of treatment for his accident injuries is listed at April 14, 1974, the

day after the accident, and this date of treatment was for emergency or outpatient treatment at hospital. His attending physician is a Doctor R, and during the course of this period of treatment in 1974 Doctor R referred to an orthopedic specialist a Doctor C. Also included in this total was a course of physiotherapy by a Mr. H of [address], Willowdale, Ontario.

Later claimant had a course of physiotherapy treatments from a Mr. T also of Willowdale for a course of 31 treatments which ended on July 22, 1975 and the charge for this course of treatments was \$156.55.

Claimant continued to consult with his own family physician Doctor R through 1974 and into 1975.

On January 22, 1975 claimant was examined by two neurologists a Doctor L for a total charge of \$36.00 and by a Doctor F, for a charge of \$20.70. Also on the same date there is a charge for x-rays performed at the North York X-ray Centre in the amount of \$45.45. Our source at this point agreed that it was difficult to justify this neurological involvement with the accident injuries almost a year before. However, it does appear that the billing for these neurologists and the x-rays done on January 22, 1975 were included in a final total which was apparently presented to your company in the amount of \$596.63, which your company has apparently paid.

The record goes on to indicate continued visits to Doctor R's office extending into May 16th, 1975.

On September 8, 1975 there is a charge for \$10.80 by a Doctor I listed as emergency out-patient treatment for a condition which is coded as an "epileptic seizure". It would appear from this that the claimant was brought to or requested treatment at a hospital following a seizure or convulsion. There is also a bill for out-patient visits

on September 8 and September 23, 1975 for a total of \$36.20, presumably connected with this epileptic seizure.

Due to some error in O.H.I.P.'s record the hospital involved is not identified.

We have attempted to identify Doctor I but there is no doctor by that name listed in the current telephone book. Checking with the College of Physicians and Surgeons they report no doctor in private practice or working in a hospital by this name. They suggest name might be I and of these there are two. There is a Doctor I in Brampton and a Doctor I in Burlington. There is no information at the College of Physicians and Surgeons to indicate the hospital connections of either of these doctors.

The O.H.I.P. record continues showing a visit to Doctor R's office on September 16, 1975 followed by an office visit to a Doctor C a psychiatrist, the bill for his consultation being \$37.80.

On September 23, 1975 there is a charge from a Doctor Ro listed as a general practitioner, with a bill of \$9.00. Doctor Ro's involvement here is not clear.

On September 24, 1975 claimant again had a consultation with Doctor L, the bill for that service being \$22.50. This is the neurologist previously mentioned.

On October 27, 1975 there is a bill from a Doctor T in the amount of \$48.06 and Doctor T is a specialist in internal medicine, the service he provided was a brain scan for brain tumour localization, and Doctor T's service is listed under nuclear medicine.

Doctor R saw claimant again on November 24, 1975 for a regular office visit.

At this point the O.H.I.P. file became inactive, but in August, 1976 they were advised of an additional amount to be posted to this

file in the amount of \$38.25. This was for x-ray services performed by a Doctor R.S. Shumak on February 5, 1976 and for an office visit to Doctor R on the same date.

Our source spent some time with us going over this O.H.I.P. file as it appears to be a rather involved and completed list of treatments and services performed on Mr. .

He admits that the neurological involvement is difficult to connect with the original accident injuries and apparently your company has had some correspondence with O.H.I.P. challenging some of the billing. There are no other references to epilepsy, and no information to indicate any previous treatment or history of epilepsy involving .

Our source cautioned that the coding used to describe the particular complaint for which was treated on September 8, 1975 covers a number of conditions, usually describing a convulsive type fit or seizure, but perhaps not accurately descriptive of an epileptic seizure. There is nothing in the file to indicate that any doctor had ever made a diagnosis of epilepsy, but at least there was an attempt to determine if had a brain tumour when the brain scan was done in October, 1975.

You may wish to compare this information with correspondence you already have from O.H.I.P., and if you have any questions, we might be able to take the matter up with O.H.I.P. later.

It is clear that Mr. Gordon disclosed that the subscriber had been treated by a neurologist for what was coded as an epileptic seizure, examined by a psychiatrist, and that a brain scan had been performed. It is significant that the coded documents in the OHIP file had the term "epilepsy" and the words "brain scan" in someone's handwriting. Mr. Gordon was unable to give any reasonable explanation for this incident. The release of information under these circumstances was inexcusable and highly improper.

In another case a child, whose health-care costs were covered by OHIP, was involved in a motor vehicle collision. A solicitor was retained to act on behalf of the child and to represent OHIP's subrogated interest. Mr. White obtained information from Mr. Gordon. The relevant position of Mr. White's investigation report read as follows:

Confidential Source,
Toronto, Ontario.
June 20, 1974.

Source confirms that O.H.I.P. does have a file open on this claimant for the purpose of recovering monies paid out by the plan in connection with the treatment and hospitalization of this claimant, the victim of an accident.

The records show that the boy was injured in an accident in Midland at approximately 4:15 p.m. on the date in question, although their records show the date to be November 18, 1968, while your record indicates November 19, 1968. The location of the accident is given as William Street and Hugel Street in Midland. He was a pedestrian hit by a motor vehicle. Claimant was taken immediately to the St. Andrews Hospital in Midland, Ontario, where it would appear that Emergency only treatment was given to him as there is no indication of any admission at that hospital for this claimant.

It would seem that the claimant's injuries were diagnosed as particularly serious and source speculates that he was immediately transferred from Midland to Toronto probably the Hospital for Sick Children in Toronto because of their speciality in handling serious injuries especially brain damage injury. However, his record does not show any added admission to the Hospital for Sick Children for 1968.

The next entry showing hospital care and admission is for the Ontario Crippled Children's Centre in Toronto where claimant was admitted on February 13, 1969, and

detained as a patient until the 6th of March, 1969, a total of 21 days. The total amount which O.H.I.P. hopes to recover for this treatment at the O.C.C.C. is \$1,153.95. This is based on a per diem of \$54.95 per day at the centre at that time.

The next entry shows an admission to the Hospital for Sick Children, Toronto, on June 7, 1972, and he was discharged from the Hospital for Sick Children on June 28, 1972, again a total of 21 days of hospital care and treatment, this time the total bill being \$2,201.85, at a per diem rate of \$104.85.

The provisional diagnosis listed on the admission chart for the Hospital for Sick Children for the 1972 admission is "Chronic Osteomyelitis of the left femur".

Source reports that throughout the file on this particular claim there is no mention of a head injury or brain damage injury.

The diagnosis of Chronic Osteomyelitis of the left femur is taken to be as one of the results of this accident, and it is being treated both by the hospital and by O.H.I.P. as an injury received in the original 1968 accident.

There is no mention of any diagnosis for his admission to the Ontario Crippled Children's Centre. Source speculates, however, that he probably had a period of active care and treatment at the Hospital for Sick Children and when his wounds were sufficiently healed and if there was evidence of brain damage such as paralysis or loss of use of a limb or of one or other of his faculties, he would have been sent to the Ontario Crippled Children's Centre for rehabilitation or possibly for assessment of the degree of his disability.

Source indicates that psychological testing is covered under O.H.I.P. under certain conditions. He has no information to

indicate that there were any bills for psychological testing done either at the Hospital for Sick Children or the Ontario Crippled Children's Centre.

The mother of the child was listed as Mrs. , and although it is not clear it does seem as if the child was covered under her O.H.I.P. plan. There is no record of the husband being the actual policy holder.

The family are represented by a lawyer, a Mr. Robert Osborne of the law firm of Black & Osborne, one firm at 111 Richmond Street West.

O.H.I.P. file number is .

The O.H.I.P. number under which the claimant has received all of the above treatment is .

Source explained that his file was obviously incomplete and he would have to check further to cover all of the missing entries and he could only speculate that this problem had arisen because of the change over the systems when O.H.I.P. went into effect in April, 1972. Previous records were not always successfully transferred to the new system. He did offer to get in touch with the lawyer on the case and obtain the necessary information from him including any comment from the lawyer regarding the cost and nature and location of any psychological testing that may have been done. He suggested that we hold our file in obeyance for about two weeks at which time, he hoped to be able to help us with this additional information.

A review of this report indicates that Mr. Gordon offered to contact the infant's solicitor to obtain particulars of the infant's condition. A letter was written on July 12, 1974 by Mrs. R. C. Gandz, who was also employed in the subrogation department. It is in the following language:

July 12, 1974

Black, Osborne, Black & Bassell
Barristers and Solicitors
111 Richmond St. W.
Toronto, Ontario

Attention: Mr. Robert Osborne

Re: Our File:
Accident: November 18, 1968

Dear Sir:

Further to our letter of July 12, 1973,
please advise us the current status of this
matter.

We are attempting to update our records,
however, there appears to be some confusion
as to the dates of confinements at
St. Andrews Hospital in Midland and Sick
Children's Hospital in Toronto. We there-
fore, would appreciate your forwarding to us
copies of all medical reports which you may
have in your file in order that we may have
a complete picture of all treatments
received by .

We appreciate your co-operation and await
your further advices.

Yours truly,

(Mrs.) R. C. Gandz
Claims Adjuster
Subrogation Division

RCG/ab

Mr. Gordon acknowledged that this letter was written as a result of his conversation with Mr. White. It is significant that the letter does not disclose the investigator's inquiry. I find it incredible that Mr. Gordon would have this request made when OHIP's interest was so closely identified with that of the child. I can think of no explanation for attempting to obtain confidential health information from the child's solicitor to pass on to Mr. White, an investigator acting in an interest adverse to that of the child and OHIP. As it transpired, the

information was not forthcoming sufficiently quickly and Mr. White reported to his principals as follows:

This is further to our report to you dated June 26, 1974. As indicated in that report, we have been in touch with a confidential source with access to O.H.I.P. records. That source indicated that the O.H.I.P. file was incomplete, and offered to make further inquiries for us, specifically to get in touch with the lawyer representing the child, and request from that lawyer, additional information regarding treatment, psychological testing, etc.

We have followed up with our source, and he reports that the lawyer had not answered his request for this additional information, and in view of the time that has elapsed, he can only assume that the lawyer does not intend to supply this information. Accordingly, he recommends that we close our file, at this time. He did promise to contact us if he did receive some additional information, either from this lawyer, or through the normal channels of O.H.I.P. administration.

In view of this, we can close with this handling. Naturally, we will advise if we hear anything further from our confidential source, regarding the treatment and testing of this Claimant.

Please add this to your file, on this case.

This was not the only occasion on which Mr. Gordon requested medical reports on Mr. White's behalf. The following is another example of the provision of substantial health information, all of which Mr. Gordon acknowledged giving to Mr. White. The information set out in the investigator's report was the following:

As we discussed, we next checked with a confidential source with access to OHIP records.

We attended at the offices of this confidential source and were able to obtain, direct from their records, and file on this

case, the following details regarding Mrs. 's treatment.

OHIP's file number is . The information is current as of September 19, 1975. The total amount of OHIP interest up to this time is \$5,523.70.

The first entry is dated January 10, 1974 and is for emergency out-patient treatment at Mississauga Hospital and the amount of \$14.70.

On the same date medical services were provided by a Dr. S and the amount involved is \$4.50, the exact service provided by this doctor is not listed.

On January 15, 1974, x-rays were taken and a bill for services from a Dr. K, show two amounts, \$31.50 and \$18.00.

The next date is January 17, 1974 for a Dr. C in the amount of \$8.10.

The next date in sequence is January 31, 1974, services provided by a Dr. D for \$13.50. The next entry is dated February 21, 1974, again for Dr. D in the amount of \$5.40.

The next date is March 10, 1974 to and including April 24, 1974, a charge by the Queensway General Hospital for hospital admission, 45 days at \$63.35 per day, for a total of \$2,850.75.

Next therein a bill for services provided by Dr. D from March 11-30, 1974 and the amount is \$45.00. Also for Dr. D from April 2-23, 1974 in the amount of \$45.00. Again Dr. D for May 2 and 3, 1974 for a total of \$12.06.

There is a charge for services by a Dr. C on May 24, 1974 for \$6.03.

Next there are three dates of service by Dr. D, these being June 13, 1974, July 25,

1974 and September 12, 1974 and each of these visits shows an amount of \$6.03 per visit. It is pointed out to us that \$6.03 is the amount allowed by O.H.I.P. for a regular visit to the doctor's office.

There is a charge for a Dr. O from March 13 to 31, 1974 for \$17.10. This particular service is not described but would presumably be services provided by this doctor during Mrs. 's stay in hospital at Queensway General.

The same doctor has also a bill for services from April 1-22, 1974 for a total amount of \$18.90. There is a bill from a Dr. L for services between April 1-8, 1974 for a total amount of \$28.80.

On April 3, a Dr. M for \$34.20.

The next hospital entry is again for Queensway General Hospital from February 23, 1975 to March 21, 1975 for a total of \$2,141.15. There is also a charge from the Queensway Hospital for physiotherapy provided between April 2-21, 1975, a total of seven treatments at \$5.05 per treatment for a total of \$35.35.

Other doctor's bills are December 12, 1974 and February 6, 1975 for Dr. D, at \$9.63 each and between February 23 and March 10, 1975 a total of fifteen visits at \$4.50 a visit for a total of \$67.50.

Dr. D again saw the patient on March 11, 1975 for a total of \$4.50. On April 1 and 15 and 22, 1975 Dr. D again saw the patient, his bill being a total of \$18.09. He saw her again on May 6, and 23, 1975 for a total of \$12.60.

He saw her again on June 3 and 17, 1975 for a total of \$12.60.

There is a bill from a Dr. J. Forks or Fooks (name is difficult to read) for services to Mrs. K on January 27, 1975 for a total of

\$6.03. There is also a bill from a Dr. O for services from February 19, 1975 to April 21, 1975, 29 services at 90 cents each, for a total of \$26.10.

The last entry is for a Dr. Ke for services on May 1, 1975 for a total of \$9.06.

Please note some of the information above was taken from a photocopy which was not always clear and the figures have not been checked against the total so there may be some slight discrepancies.

We advised our source of what appeared to be an incomplete collection of medical reports made available to your company and he accordingly made arrangements to request these medical reports for his department. He offered to make these available to us as soon as he received them, but he anticipates a delay of several weeks before these are available to him.

On checking the admission to Queensway General Hospital between February and March 1975, there is nothing on the record to indicate any surgical procedure or any excessive charge at all to justify Mrs. being admitted to hospital. It does appear that she was admitted there for what appears to have been a period of rest and hospital care, combined with physiotherapy, and on the basis of this he would have to agree that her stay in hospital was longer than usual on cases of this type. Also he notes that there was a doctor of physical medicine involved in Mrs. 's treatment. This is an M.D. who specializes in the care and treatment of people with functional disorders of the back or muscles. In short, he is very much like a physiotherapist, but holds an M.D. degree as well.

Although he admitted that he had provided all of the particularized health information, Mr. Gordon denied that he had agreed to request medical reports for Mr. White. I believe that Mr. Gordon did in fact have a conversation with Mr. White in which he agreed to obtain medical reports. There is a notation

in the file, dated October 14, 1975, in Mr. Gordon's handwriting, addressed to Mr. Godden which reads as follows:

Request - med. reports re. recurring back condition.

As a result of these instructions, Mr. Godden, in fact, telephoned the subscriber's solicitor, and requested delivery of all medical reports which, in due course, were sent to OHIP. Mr. Gordon did not advise Mr. Godden or the claimant's solicitor of his conversation with Mr. White. Mr. Gordon acknowledged that this conduct would be improper. His exchange with Mr. Strosberg is as follows:

Q. Would you agree it would be improper for you to request medical reports for the purposes of showing them to Mister White or providing information from them to Mister White?

A. I can't think of an occasion when I received medical reports that I gave to an investigator.

Q. Would you agree that to ask for medical reports from a lawyer intending to pass some or all of the information contained in those reports on to an investigator would be an improper thing for you to do?

A. Yes.

There is no doubt that, in breach of his obligation under The Health Insurance Act, 1972, Mr. Gordon released confidential OHIP health information to Mr. White. His reason for doing so is much more difficult to discern than that he did so. One reason may be quickly eliminated. He received no compensation or other consideration in return for the information he gave Mr. White. It was my impression, at our hearings, that Mr. Gordon was surprised when it became evident how much confidential health information he had revealed to Mr. White. He believed that Mr. White was his friend. He also believed that their "communication was on a higher plane" than appeared from the reports. Mr. Gordon did not think that Mr. White would include in his report "every nitty gritty little thing...that (he) had maybe said as (he) was reviewing something." As Mr. Gordon explained it, "I am trying to get to the meat of the problem and I may have to cull through a little bit of information to get there." Mr. Gordon admitted that he would not have

told Mr. White what he did had he known that everything would be reported verbatim to his principal. With a trace of sadness, Mr. Gordon said that he was "a little disappointed in him (Mr. White). More than disappointed."

I think that those quotations best illustrate Mr. Gordon's true feelings. He ought to have known that, as an investigator, Mr. White's function was to obtain information, that to Mr. White information was money, and that, for these reasons, every scrap of information would be duly transmitted to Mr. White's principals. It seems likely, however, that, despite the obvious, Mr. Gordon did not actually realize these self-evident truths. Mr. White was an articulate, personable man who persuaded Mr. Gordon that he was of use to Mr. Gordon because, from time to time, he brought to OHIP's attention the existence of accidents and injuries to subscribers of which OHIP was unaware. Mr. Gordon unwittingly became involved in a situation in which he was trading information with Mr. White. It is probable that he never really appreciated that this had happened, even when the evidence was brought out at our hearings. In short, Mr. Gordon is another example of an individual permitting his friendship or relationship to blind him in the execution of his duty.

Because of what has been learned at this inquiry and because of an important development in OHIP's subrogation practice, Mr. Gordon's offending behaviour is not likely to be repeated. The insurance industry and OHIP have entered into an agreement whereby OHIP is reimbursed by individual insurance companies on the basis of the percentage of premiums charged, rather than through subrogation. The arrangement is accurately summarized in a letter dated November 21, 1979, from Alexander Kennedy, assistant general counsel for the Insurance Bureau of Canada, to Carene Smith, my associate counsel. The relevant portion of the letter reads as follows:

I am enclosing, as you requested, a sample copy of the standard form of agreement and the following background information may be of some help to you.

In 1971, discussions were first held between I.B.C. and OHIP to develop a formula under which the Plan could be reimbursed by the insurance industry instead of the cumbersome and costly system of subrogation. In the I.B.C. Submissions to the Select Committee on Company Law, reference was made to this proposal and in its first report, the Select

Committee recommended that action be taken to simplify the procedure and reduce the expenses of the Ministry of Health in their recovery of subrogated rights.

Flowing from the Report of the Select Committee on Company Law, I.B.C. was approached by the Ontario Department of Insurance and the Ministry of Health to develop a formula which would permit the elimination of all subrogated claims against automobile liability insurers by OHIP. Agreement was reached with OHIP along the lines of the Agreement attached, and this was approved by our Board of Directors.

Basically the Agreement calls for monthly payments by all insurance companies which accept the Agreement of approximately 2% of direct written automobile third party liability premiums. The Agreement became operative as of December 1, 1978 and case-by-case subrogation against automobile liability insurers in respect of accidents occurring on and after that date have now ceased. Payments to the Ministry are interrelated with the payment of premium taxes, although they are, in fact, made directly to the Ministry of Health. They are payable on the last day of each month commencing March 31, 1979. The payments for March to December, 1979 and for January and February 1980 are based on 1978 premiums, and a similar pattern is adopted for subsequent years. The Agreement remains in force until December 31, 1980 and can be terminated by the Minister or by any insurer on one year's notice prior to that date. If no such notice is given, the Agreement continues until one year's notice is given by either party.

The Ministry of Health insisted that individual agreements be signed with every automobile insurer in the province, and the vast majority of companies have now signed the Agreement. I understand that the Ontario Superintendent of Insurance makes it a condition of licence for any new companies

wishing to write automobile insurance. To the best of my knowledge, the 100 or so companies who have not signed it are mainly companies who are virtually doing no automobile insurance business in the province.

The payment provisions in clause 3 are somewhat technical and the interest provisions are simply a reflection of the provisions of the Corporations Tax Act relating to interest on outstanding amounts of premium tax. The final parts of that clause are simply to ensure that, e.g. an increase in the rate of premium tax will not in itself increase the amounts payable by insurers.

To the best of my knowledge, the Agreement is working extremely well, both from the point of view of OHIP and the insurance industry.

The effect of this arrangement will be substantially to reduce the OHIP subrogation department's involvement with insurance companies. Certainly, the right of subrogation will continue to exist in cases in which subscribers are injured by the negligent acts or omissions of third persons in situations other than those involving motor vehicles, such as medical malpractice cases and occupier's liability cases. However, the quantity of health information dealt with in the subrogation department will be considerably reduced and, as a result, the risk of exposure to investigators will also be significantly reduced. I add that Mr. Gordon is a capable and conscientious administrator. His relationship with Mr. White was a departure from the otherwise proper conduct of the duties of his office.

Recommendation:

7. That the subrogation department of OHIP refuse to provide any information to private investigators. The department should deal only with licensed insurance adjusters, insurance companies, or solicitors in attempts to settle its subrogated claims.

Charles Clarke Wright, who was the president of W.A. King Ltd., gave evidence at our hearings. He had been a staff adjuster with an insurance company for approximately 12 years before joining W.A. King Ltd. in 1968. At all material times,

Mr. Wright knew that Mr. White had a confidential source at OHIP. By his own estimate, Mr. Wright had read between 500 and 1,500 investigation reports during his career as an adjuster. When questioned by Mr. Strosberg as to whether any other investigator had ever provided him with reports containing information from OHIP, Mr. Wright had this to say:

Q. Now, we come back to investigation reports and I think you have said that using ballpark estimates that you had probably read somewhere between five hundred and fifteen hundred investigation reports?

A. That could be.

Q. Now, have you read any of Mister White's reports that are before the Commission?

A. Yes.

Q. Have you ever received reports from other investigation firms which contained medical information obtained from O.H.I.P. to the same extent that Mister White's reports did?

A. I don't believe I ever have.

Q. Have you ever received a report from another investigation firm which sets out information from O.H.I.P. about prior medical history?

A. Not that I can remember.

Mr. Wright was an experienced and competent adjuster. He candidly admitted that, on occasion, he had gone to schools and hospitals in an attempt to obtain health information about claimants. He knew of the operation of OHIP's subrogation department and had, quite properly, contacted OHIP in an attempt to negotiate directly with the subrogation department on behalf of an insurer. Despite his experience, he had never personally attended or contacted OHIP in an attempt to obtain particulars of treatments, the names of physicians, the dates of treatment, or the amounts expended in cases in which OHIP had retained the subscriber's solicitor. Nor had he ever attended at OHIP to attempt to obtain particulars of prior health history. The reason he had never done so was because he believed that he would not have received the information had he sought it and he

knew that there was an obligation upon the OHIP employees to keep the information confidential. As president of the corporation and as an adjuster, Mr. Wright knew that Mr. White was obtaining health information from OHIP quite improperly, and did nothing to cause him to stop.

Mr. Wright's ethical position, as put forward in his testimony, left much to be desired. He testified that it was an adjuster's cardinal rule, and his cardinal rule, that he not deal directly with a claimant when the claimant had retained a solicitor. He would not do so and would not allow his secretary to do so. Nonetheless, while stating that he could not avoid his professional ethical responsibilities by sending a secretary to do something that he, himself, could not do, he said that investigators "would not be bound by the same guidelines, necessarily." He added that, although he personally held these ethical views, he did not believe that it was necessary for W.A. King Ltd., as a corporation, to adhere to the same standards. To state these propositions is to reject them. An adjuster cannot send an investigator, or anyone else, to carry out an act which would be unethical or improper for him to carry out. Nor may an adjuster, by incorporating, shirk his ethical obligations.

Mr. Wright acknowledged that he had always been aware that there was, as he put it, "an onus on doctors to keep medical information confidential" and that most hospitals insisted on an authorization before releasing information about their patients. He went on to say:

I always presumed that this was part of the Hippocratic oath or whatever it is. As far as employees of hospitals, again I am, not ever having contacted accounts department or the other departments that you mentioned earlier, I don't know about all of the other employees of all the hospitals. I presume that a doctor in charge or nurse in charge of a particular case has a certain obligation...

Mr. Wright conceded that he knew that he had an obligation to keep information that he collected on behalf of his principals confidential and when asked whether or not he therefore believed that a physician had a similar obligation, he stated,

I am a semi-professional; he is a professional. If he deems it necessary to give me information that is his problem.

A fair interpretation of his position is that Mr. Wright knew that it was improper to obtain health information from physicians, physicians' employees and hospital employees without the authorization of their patients. He admitted that he had gone to hospitals, on a very few occasions and in unusual circumstances, in an attempt to obtain that sort of information. Had he thought it proper, I believe he, personally, would have continued to attempt to obtain such information himself. He did not do so because he knew that it was improper. He must have believed that he could avoid acting improperly if he had someone else do what ought not to be done.

I am satisfied that, at all times, Mr. Wright knew that investigators employed by C.C.R. were obtaining confidential health information from hospitals, hospital employees, physicians and their employees without patient authorization and did nothing to stop the practice. He testified that he did not believe that private investigators ought not to have been retained for the purposes of obtaining medical information without the authorization of the patients from hospitals and from physicians. It may be that it was only stubbornness on Mr. Wright's part that caused him to make such a statement. Any reasonable person, looking at the conduct of the C.C.R. investigators, could reach no other conclusion than that the investigators ought not to have been retained by W.A. King Ltd. for this purpose.

I also heard evidence from Geoffrey Taylor and Edward Douglas Gooderham, who also were adjusters employed by W.A. King Ltd. and principals of the company. They both knew that Mr. White was obtaining confidential health information from hospital employees and physicians and their employees without patient authorization and did nothing to put an end to these practices.

Recommendation:

8. *That no individual, partnership or corporation carrying on business as an insurance adjuster be permitted to carry on business as a private investigator or own an interest of any kind in a corporation licensed as a private investigator under The Private Investigators and Security Guards Act.*

Cortlaw Services Limited

Cortlaw Services Limited, which I shall refer to as Cortlaw, is an Ontario corporation whose head office is in London, Ontario. Throughout the relevant period it was licensed as an investigation agency and carried on business in the County of Middlesex and the surrounding areas. Earlier, I described the practice which we developed of asking every person and corporation whose participation in obtaining information about the health of patients without their consent we discovered, and who agreed to co-operate, to search their records and deliver to us other investigators' reports containing information of that kind. It was by this means that we became aware of Cortlaw's activities.

The shareholders of Cortlaw were Michael Joseph Cortese and Kenneth Wayne Laidlaw, both of whom are licensed private investigators. They and Dennis Bannon were Cortlaw's licensed investigators. The name of the company derived from a syllable taken from the names of each of the principals, Cort from Cortese and law from Laidlaw. Messrs. Cortese and Laidlaw were products of the network of offices belonging to Retail Credit Company of Canada Ltd., now Equifax Services Ltd. They were both employed by that private investigation agency and it was there that they obtained their early experience and learned the tricks of the trade.

In my discussion of the business of Centurion Investigation Ltd., I dealt at some length with pretexts and the use of pretexts to obtain confidential health information without patient authorization. Generally speaking, it is difficult to attribute moral wrongdoing to a custodian of confidential health information who is made the victim of a pretext and, as a result, releases the information because that person was tricked by the practitioner of the pretext. This is not to say, however, that greater care could not, and ought not, to have been taken by the person tricked. Nor does it justify the general lowering of reasonable care that prevailed throughout the health-care sector, as far as confidentiality was concerned, before the creation of my inquiry and its attendant publicity. I will have occasion to return to this point again. For present purposes, it is enough to say that Cortlaw's method of obtaining

confidential health information purported to be different. It was its position that, although pretexts were used regularly to obtain information from, for example, neighbours and employers, they were not used to obtain confidential health information from hospitals, physicians' offices and other health facilities. Messrs. Cortese and Laidlaw claimed that, despite the absence of patient authorization, confidential health information had been given to them voluntarily and thus, by necessary implication, in violation of the providers' duty to keep the information confidential. Here, for example, is an exchange which occurred at our hearing in London between Mr. Strosberg and Mr. Laidlaw:

Q. Now, when you have approached a doctor's office or hospital employees to obtain medical information, have you used pretexts?

A. No.

As a result of this position, many physicians and hospital boards in the London area sought and were granted standing at the hearing in order to challenge the position. It was their position that only where Cortlaw's employees had used pretexts did they receive confidential health information.

Mr. Cortese and Mr. Laidlaw both testified that, before the commencement of our hearings, they did not believe that physicians, hospitals or hospital employees had any obligation to keep the health records of their patients confidential. Any restriction of the release of health information, they thought, was a matter of individual ethics and hospital policy rather than a matter of law. They went on to say that it was their view that, as private investigators, they were entitled to obtain from hospitals and physicians, without the patient's consent, a patient's OHIP number, the dates of admission and discharge from hospital, the names of the patient's family physician and specialist, the amount billed and the amount paid by OHIP. It is my opinion that this belief could not have been reasonably held. Both of these men knew that, as a general rule, they required a written authorization from the patient before they could obtain health information about that patient from a hospital. The belief which they claimed to hold was neither based on reason nor consistent with their later evidence. For example, on the question of the information he was entitled to receive from hospitals without patient authorization, I cite the following answers given by Mr. Cortese to questions put to him by Mr. Strosberg:

Q. Well, is it your view then, really, it comes down to you are entitled to whatever you can get?

A. Yes, I would say so, yes!

Q. Well, you have told me, you made the statement that some medical information is not confidential. That seemed to me to lead irresistably to the inference that you believed that some medical information was confidential and was obliged to be kept confidential by the hospital?

A. Right.

Q. What are they obliged to keep confidential?

A. I would say the entire medical report.

Q. Well, if you have got the dates of treatment, the date of admission and discharge, the OHIP number, the name of the family doctor, the name of the specialist, the billing costs and the amount that was paid by OHIP and details of treatment, what else is there?

A. There is a lot more information in their history sheets.

Q. Isn't that substantially all the information?

A. That's the basics of it.

Q. That's the basics?

A. Yes.

Q. Is there anything that you believe that a hospital had to keep confidential? Or was it just as you said, whatever you could get you were entitled to?

A. Yes, that's my feeling.

Q. That's your feeling? So far as you were concerned, you weren't concerned as to whether or not the hospital had an obligation to keep anything confidential. Whatever you could get from anyone, you would take without concern for what the hospital's obligation was?

A. I guess that would be right.

I am satisfied that Mr. Cortese knew perfectly well that physicians, hospitals and their employees were required to protect the confidentiality of their patients' health records. My conclusion is supported by the method of approach used by Mr. Cortese. If he had truly believed what he said he believed, he would have identified himself and his interest directly and truthfully when he sought health information. He would have said something to this effect: "I am Michael Cortese of Cortlaw Services Limited, a private investigator. I have been hired by the X Insurance Company to obtain information about your patient who is probably going to sue X's insured. Your patient does not know I am seeking this information and, of course, has not authorized its release". Needless to say, nothing close to that frankness was employed. Whenever he sought confidential health information Mr. Cortese used one of the following introductions:

- (a) We have been asked to assist in the processing of a disability claim;
- (b) We are working in connection with a disability claim;
- (c) We are working on a disability claim;
- (d) We are processing a disability claim of your patient;
- (e) We have been asked to assist in the processing of an injury claim;
- (f) We have been asked to verify the dates he was in the hospital, and if the bill has been paid.

I am not, of course, suggesting that the hypothetical introduction set out above ought to have been used. It would certainly have been self defeating. My point is that if Mr. Cortese had genuinely believed that there was no impediment in the way of his having the information he would not have resorted to the introductions that he invariably employed. The fact is that his approaches were misleading and were intended to be misleading. Not only were they not fully informative, they were quite inaccurate. Mr. Cortese was not assisting in the

attempting to obtain information for an insurer whose interests were adverse to those of the patient. He used the verification approach even when he had no information to verify. Mr. Cortese knew that if he had fully and correctly identified himself he would not have obtained as much information as he did obtain. Indeed, he probably would have received no information at all. That, simply, was why he was taught to use the introductions he continued to use.

Mr. Laidlaw, for his part, denied that he had ever used language such as Mr. Cortese had used. This is what he said in his evidence, in answer to Mr. Strosberg:

Q. How do you identify yourself?

A. I identify myself in various ways, but normally I would introduce myself as Ken Laidlaw of Cortlaw Services. We have been asked to obtain some information in connection with a motor vehicle accident or a boating accident or whatever the case was, on Mister ... give his name. I understand he is in your hospital, could you tell me when he came in, and start from that point.

Q. I take it that you don't specifically indicate that you are acting for an insurance company who is adverse in interest from the claimant?

A. I wasn't under the impression, by the Act that we had all we had to do was properly identify ourselves, show our licence if we are requested, and I have always done that. If I have been asked by anybody, you know, whose side are you on or who are you working for, I always tell them that I am working for the people who ran into Mister so-and-so and who eventually might have to pay any losses that he has.

The implication in Mr. Laidlaw's denial is a serious allegation against these persons who provided him with health information, for if they gave the information knowing of his true interest, the breach of their obligation of confidentiality would be hard to excuse. Fortunately, however, it is unnecessary for me to analyze, in great detail, Mr. Laidlaw's lengthy testimony and the many investigation reports prepared by him because, after a searching and effective examination by Mr. Strosberg,

Mr. Laidlaw eventually admitted, on his own behalf and on behalf of Messrs. Bannon and Cortese that:

1. when approaches were made to various hospitals, hospital employees and physicians' employees, the intention was to convey a position of neutrality or that they were acting on behalf of the patients;
2. the persons to whom the representations were made believed that Cortlaw's employees were acting on behalf of the patients;
3. that belief was what the employees of Cortlaw wanted to result from the representations;
4. the creation of those beliefs was the general method of operation of Cortlaw's employees.

In addition to what was said in the introductions, there is the matter of the name of the company itself. Although it is true that it is, as I have said, derived from the names of the principals, the irresistible conclusion from all the evidence is that it was calculated to mislead. In another business it would be unobjectionable. In the private investigation business as it relates to potentially adversary proceedings it is something else again. Only the choice of Lawcourt as a name would have been more likely to cause confusion about the interests represented. I am in no doubt that the co-operation which the company's employees received from custodians of health records can be attributed, at least in part if not in large measure, to the fact that, when the name Cortlaw is spoken, it suggests an official connection or an association with the official processes of the law because, of course, it sounds like the words court and law. Again, Lawcourt would have been less subtle. I am satisfied that the name was selected because of the connotation with officialdom, thus adding credibility to the intended impression of neutrality that was conveyed in the introductions.

Recommendation:

9. That The Private Investigators and Security Guards Act prohibit the use by a licensee of any business name

suggesting a connection or association with the law or the legal system.

One hundred and thirty-six investigation reports prepared by Cortlaw were placed in evidence. All of these reports conclude with the heading, "Sources Seen In Investigation". Under the hearing, names and places are listed. For example, a report dated January 20, 1977, addressed to The Co-operators, contained the following concluding section:

SOURCES SEEN IN INVESTIGATION:

1. Mrs. H - Fanshaw College -
Oxford St. E., London.
2. Mr. S - Secord Lawn and Garden Equipment
- Harrietsville.
3. Interviewed mother January 11, at
4:45 p.m.
4. Mrs. - Mossley - known 15 years.
5. Mrs. - Mossley - across the road -
known 4 years.
6. Mrs. - President of the 4H Club and
lives two doors away - Mossley - known
15 years.
7. - Avon Milling Co., Avon - known
15 years.
8. Mrs. - Mossley - known 10 years.
9. Miss and Mrs. - Store - Avon -
known 2 years.
10. - personal friend - known life -
Avon.
11. - Avon - personal friend - known 5
years.
12. Confidential source - medical records -
Victoria Hospital - London.
13. Confidential source - office
Dr. G - St. - London.
14. Dr. C - surgeon - St. - London.
15. Confidential source - Dr. R
- St. , - Ingersoll.
16. Confidential source - Dr. W - surgeon -
- London.
17. , H & H Silos - bookkeeper.
18. Secretary, Lord Dorchester Secondary
School - 61 Queen St. - Dorchester.

The lists compiled for the investigation reports prepared by Cortlaw employees were also deceptive. The impression given by the lists was that all the "sources" mentioned provided information. That, however, was not the case. Even if no

information had been received from a so-called source, his or her name or description was included. The lists were not lists of sources; they were lists of persons approached, whether or not they gave the investigators any information. According to Mr. Cortese, for Cortlaw's purposes, there was no difference between a confidential source and an anonymous person who refused to give any information. It is clear that Cortlaw's clients must have been deceived into believing that Cortlaw had special contacts and sources not available to anyone else. As far as health-care providers were concerned, the fact that, say, a physician's name appeared as a source meant, not necessarily that he or she provided any information about the patient but only that his or her office had been approached; even when a physician's employees refused to divulge information, the physician or the physician's office was listed as a source. For example, although in the example given above, Dr. C, whose real name has been omitted for obvious reasons, is named as a source, he was not personally spoken to. Yet the only reasonable inference for The Co-operators, Cortlaw's client in this case, to draw was that that physician had been a source of information for the investigator.

Under section 5(2) of The Public Inquiries Act, 1971, S.O. 1971, Vol.2, chapter 49, notice was given to many physicians and hospital administrators that allegations of misconduct were being made against them or their hospitals because Cortlaw investigation reports had shown them to be sources of information. This procedure made it possible for inquiries to be made to determine if office or hospital practices were such that employees were giving information which their employers were obliged to keep confidential. It is no answer, for example, for a physician to say that he or she did not himself or herself make the prohibited disclosure but that his or her secretary did. It is surely incumbent on a physician to ensure that his or her staff realizes that security for patient information is essential. At our hearing I heard the evidence of these physicians, their employees and various hospital administrators. Because of the admission made by Mr. Laidlaw that pretexts were used to obtain confidential health information, it is unnecessary for me to deal extensively with the explanations given to me except to say that it seems clear from them that those persons, whether they were physicians or employees of physicians, who released information believed when they did so that they were helping their patients in the collection of pecuniary benefits.

The investigation reports admitted in evidence were sent to the following clients of Cortlaw:

Royal Insurance Company of Canada
Thomas, Williams & Rowell Insurance Adjusters Limited
Fireman's Fund Insurance Company of Canada
Anglo-Gibraltar Group
The Co-operators
Northland-Crawford Insurance Adjusters
Commercial Union Assurance Company Limited
Morden & Helwig Limited
MacPherson Adjusting Services Limited
The General Accident Assurance Company of Canada
Lumbermen's Mutual Casualty Company
Shaw & Begg Insurance Group
The Guarantee Company of North America
Federal Insurance Company
Underwriters Adjustment Bureau Ltd.
The Wawanese Mutual Insurance Company
S.J. Kernaghan Adjusters Limited

I am satisfied from all the evidence, including Mr. Cortese's statement, that these clients knew that Cortlaw's employees sought confidential health information without patient authorization. None of the clients ever complained to Cortlaw about the receipt of this type of information and Mr. Cortese had good reason to believe that Cortlaw's clients accepted the procedure as an ordinary business practice. In fact, their clients instructed Cortlaw to carry out investigations when their employees knew or ought to have known that, as part of the investigations, Cortlaw would seek to obtain and would obtain from hospitals and physicians' offices confidential health information despite the absence of patient consent. They must have known that this meant a breach of the obligation of confidentiality and they ought not to have retained Cortlaw for this purpose.

Jolie & Todd Investigations

Jolie & Todd Investigations is a partnership which was established in 1973 by John F. Todd and George Jolie. This company carries on an investigation business in Windsor and the surrounding area. From time to time, its employees have worked in Detroit, Michigan, although not licensed to do so. Mr. Todd and Mr. Jolie were experienced private investigators at the time of the events to be discussed. Both obtained their early training with Retail Credit Company of Canada, now Equifax Services Ltd. In fact, Mr. Jolie was, at one time, the Windsor claims director for Equifax. Charles Richard Stickley, a licensed private investigator, was the only other licensed investigator employed by Jolie & Todd Investigations.

Our hearings in Windsor took seven days and dealt not only with the activities of Jolie & Todd Investigations and their customers, but also with the attitudes and actions of persons and institutions in the Windsor community who were custodians of health information. These attitudes are, in my opinion, representative of the attitudes held throughout Ontario and are important to an understanding of the problems of confidentiality. For this reason, I shall deal with these attitudes and actions after a short review of the activities of Jolie & Todd and their clients.

Mr. Todd admitted that at all material times he knew that physicians had an obligation to keep health information about their patients confidential and that this obligation arose as a matter of law and, as he put it, as a "matter of oath". Mr. Jolie denied knowing that a physician's obligation to keep health information confidential arose as a matter of law. He believed, he said, that it was a matter of ethics. Both Mr. Todd and Mr. Jolie testified that they knew that, as a matter of policy, all hospitals in the County of Essex would not release information about a patient without the patient's authorization, but they said that they believed that there was no obligation on the part of the hospitals to preserve confidentiality as a matter of law. It was simply a policy decision.

I do not think that Mr. Jolie and Mr. Todd actually thought about whether there was a distinction between a policy grounded

on some ethical considerations, on the one hand, and an obligation of confidentiality based on statutory requirements, on the other hand. They knew that they ought not to seek confidential health information without a patient's authorization from a physician and a hospital but, despite that knowledge, they continued to do so. Furthermore, their use of pretexts, which I shall describe below, is consistent with their knowledge that a full and frank disclosure of the interests they represented would result in a refusal of the information they sought. The manner in which they approached hospital employees and physicians and their employees satisfied me that Messrs. Todd and Jolie knew that physicians, hospitals, and hospital employees had an obligation to keep health information confidential.

When they sought confidential information, they used the following introductions:

- (a) We are handling a case for "X".
- (b) We are looking into a claim for "X".
- (c) We are looking into a routine claim for "X".
- (d) I am an insurance inspector and have been asked to look into a routine claim; and
- (e) I am an insurance investigator.

These approaches were misleading and were intended to mislead. They were not completely informative, and, in fact, were inaccurate. Mr. Todd and Mr. Jolie were not handling a claim for the claimant, but were attempting to obtain confidential health information about a claimant for an insurer whose interest was adverse to that of the patient.

Both Mr. Todd and Mr. Jolie were frank to admit that they intended to give the impression of neutrality or unity of interest with the claimant when, in fact, they were adverse to the claimant. They agreed that they would not have obtained as much information as they did obtain if they had properly identified themselves. This is an understatement. I believe they would not have received any information if they had properly identified themselves. It is precisely for this reason that they used these methods. Each of these approaches is a pretext. To my mind, the intentionally false identification of a private investigator, as, for example, an insurance inspector, or, as a person handling a case for a claimant and the description of an investigator's function as looking into a routine claim for the claimant, are all misrepresentations or tricks, used to cause a person to impart information. They are as much a pretext as the false representation that a person was an employee of OHIP. These approaches were used because physicians, or their

employees, or hospitals and their employees, believing that they were helping their patients in the resolutions of claims, would be more likely to co-operate and provide the requested information.

I shall give two examples of what I consider to be typical reports prepared by this investigation firm. On September 30, 1978, a claimant was injured as a result of a motor vehicle collision. The matter was assigned by the insurer of the person responsible to T. G. Hall Insurance Adjusting Ltd., who, in turn, retained Jolie & Todd to carry out an investigation.

The report dated December 16, 1977, was forwarded by Mr. Todd to T. G. Hall Insurance Adjusting Ltd. and, in its entirety, was as follows:

JOLIE & TODD INVESTIGATIONS
CLAIM INVESTIGATIONS
Telephone: 254-3723

REQUESTING CO.
Hall Insurance Adjusting Ltd.,
? University Ave. West,
Suite 702,
Windsor, Ont.
Dec. 16, 1977

NAME OF REQUESTOR
GRANT HALL
Claim No. G 77676
Assured Fleming House Tavern
REPORT ON: ,
Windsor, Ont.
(See remarks)

Born

NATURE OF INVESTIGATION:
Date of Claim - Sept. 30, 1977
Nature of Injury - Unknown
Claimant's Attorney - Mr. Mossman
Dates of Investigation - Dec. 2-15, 1977

SUMMARY

is single and is known to be living with a . They are believed to have been living together for the past several months. The exact residential address of the claimant is unknown to our sources at

this time. We have learned that she is using the address of , which is the address of her mother, Mrs. . The claimant herself is not known to have ever been married. She is presently in partnership with Mr. , operating a retail business known as " " located at . This business has been in operation for the past one month and is being run by the claimant herself. Although is a partner, he is not active in the business. The two of them have purchased the property which is the former and are in the process of developing a mini mall at this location. She is doing no physical work regarding the alterations to the premises, but is doing the retail sales work at this shop. Prior to this, it is understood that she was unemployed for some time and is believed to have been collecting Unemployment Insurance benefits. This could not be verified, however. Prior to this she had worked for but this would be prior to about a year ago. She had worked there for about two years. The exact dates were not available through this employer as all records are kept at Montreal and the staff has since changed. Prior to this she was employed by Metropolitan General Hospital in Windsor, working in the Department and had been there from September 1972 until June 1973, working on both a full time and a part time basis. Due to the nature of her work there was very limited record information available and the management of that department has since changed. There was no reason shown why she went from full time to part time there or for what reason she left other than of her own accord. We learn of no other employment.

As far as the claimant's finances are concerned, she has a judgment dated March 15, 1975 with Tip Top Tailors for \$59.91 plus \$6.75. There is a chattel registered by I.A.C. March 25, 1976 for \$23,615. along with a who apparently was her fiance at the time.

The claimant is known to have been treated and released from Metropolitan Hospital as a result of this fall. Confidential sources indicated that she was treated by a Dr. J and her family doctor is Dr. R. There were no X-rays taken, apparently she was sent home after being looked at, and given pain pills. It is understood that the injury occurred around 11:45 P.M. and that she did not come to the hospital until 1 A.M. and then came by ambulance. We learned here that the address was given of . She is known to be under the care of her family doctor, Dr. R and is thought to be taking physiotherapy treatment, however we have not been able to learn just where, without medical authorizations.

As far as loss of time and earnings, it is very difficult because of the fact that she is self-employed, to give any estimate, however it is felt that there is no loss of earnings from this business and she has been working in the business since it opened, although she has been wearing a cervical collar and using a cane to get around. She seems to be carrying on in a normal manner, in the operation of this retail store. Prior to this she and her friend, Mr. , had been trying to set up the business during the summer time and she has been involved in purchasing supplies for sale as well as developing the mall itself. She had done no physical work around the development however.

Her activities on a personal level are unknown due to the fact that we have not been able to develop her exact residential address at this time, however should you wish us to do a small surveillance on the claimant, and follow her home after work, or make further attempts to locate her residential address, we would be glad to do this for you. As far as her business activities are concerned, she is coming and going from the business regularly and spending a full day at the business, doing retail sales work.

We learn of no previous health problems at any time.

INVESTIGATION

A check was made of local credit records having first checked without an address. We later checked again when we developed the address shown and learned that there is a file on her going back to 1972. Records show her born _____ and that there was an inquiry from a bank on November 9, 1977, no amount indicated. There is a judgment dated March 14, 1975 from Tip Top Tailors for \$59.91 plus \$6.75 costs. It is not known if this judgment has been paid. There is also a chattel registered March 25, 1976 with I.A.C. for \$23,615.; also on this chattel is a _____ of the same address, _____. She is shown as being self-employed, operating a new business called "_____" however there is no address shown for this business. Records show that she was previously employed with _____ however there is no address for this business shown and no dates of her employment. She is shown to have worked previously with _____ for 1 year and in 1972 she was employed at Metropolitan Hospital in the _____ Department. She endorsed a loan for a mobile home for a _____ and the amount involved was \$13,695.

We next checked through I.A.C. however this source indicated that the subject's record is out and it could not be located at this time. Should they find it, they will get in touch with us. As of this writing, they have not done so.

We next checked with a confidential source at Metropolitan Hospital and learned that the claimant was treated on September 30, 1977 and that she had an injury to her sacrum and was treated by Dr. J at the Emergency Department. Record here shows her family doctor to be Dr. R. There were no X-rays taken and she was sent home with pain pills. She was injured at 11:45 P.M. and came to the hospital at 1 A.M. by ambulance. Records show her address as _____. This

information is to be kept in strictest confidence as it is through a confidential source.

Mr. ,
Windsor, Ont.

Mr. stated that he had known the claimant for the past 2 years. We also spoke with this man's mother and his sister at this address and they stated that she has not been living here for some time. They have no idea just how long she has gone from her mother's home here, but they recalled seeing her visiting here with her boyfriend, a young man in his mid 20's or possibly early 30's, who has his head shaved and drives a Corvette car. She stated that the subject had visited here quite frequently in the summer months but they have not seen her since the fall. They stated that as far as they know, she last worked at Mall at , some time ago and they are not sure whether she is still here or not. They stated that they were unaware of any injuries this fall or that she had had any health problems over the years. They indicated that she has been involved in no trouble with the authorities as far as they know and that she is really not that well known in the neighbourhood.

Mrs. ,
Windsor, Ont.

This source stated that she knew very little of the claimant, due to the fact that she has been away from the area for some time now and she was unaware of any previous health problems. She could give us no indication as to where the claimant is working.

Miss ,
Windsor, Ont.

This source gave basically the same information and could add nothing further.

We have a copy of a Windsor Star clipping dated November 29, 1977 which shows a picture of the claimant , along with her boyfriend and a friend by the name

of , loading a grill which they had just purchased from an auction at the . The clipping indicates that and hope to develop an indoor mall in a building downtown, and picked up the huge grill. They also bought stained glass panels which had adorned the top of the building, the auction being handled by Mr. . The picture does not show the claimant doing any lifting but she is standing behind the grill and appears to have something in her hand. It is difficult to see if she is actually wearing a cervical collar. She appears to be small in build with long hair, almost down to her waist.

Mr. ,
Windsor, Ont.

Mr. stated that he recalled the subject, , and purchasing items at the auction and stated that he recalled the claimant getting around with either a cane or a crutch. He did not specifically recall whether she was wearing a cervical collar and stated that he had no idea what her injury was but that he was under the impression that it might have been some sort of a permanent injury she may have had, but this was strictly a guess on his part. He stated that he did not know the claimant personally, nor did he know , for that matter.

Assistant Manager, ,
Windsor, Ont.

This source stated that there are no employees with the firm who were employed here when the claimant had been the assistant manager. This source stated that she was employed here for possibly a year or so and that this would be going back prior to about March of 1976, and that she had been employed there from 1 to 2 years as assistant manager and sales clerk. This source stated she had no idea why the claimant left but she understood that she went on Unemployment Insurance for a while, but is now presently self-employed developing a mall downtown and operating a retail store called . This

source stated that she has talked to from time to time as her sister has been employed at the store, and she never recalled the claimant being sick or laid up. She stated that she is aware that her boyfriend is a fellow who is in business with her in the development of this small mall downtown. She stated that she recalls that he is a fellow, perhaps in his early 30's, and that his head is shaved and he drives a silver coloured Corvette car. She stated that she did not know him personally and she has no idea where the claimant is living at the present time. She also is not aware of the claimant receiving any kind of an injury at any time.

Personnel Manager,
Metropolitan General Hospital
Windsor, Ont.

This source stated that the claimant had been in their employ in the Department and that she worked there from September 1972 until June of 1973. He stated that she had worked full time and then went on part time for a while, and then left of her own accord. This source stated that they have very little information regarding this claimant and could be of no further assistance. He also stated that the person in charge of the Department, Mrs. , did not go into that department until after the claimant left and would be of no assistance to us.

City Directories were also checked at this point and there is no employment shown for the claimant this past year, or for that matter, any other employer than .

Mr. ,
Windsor, Ont.

Mr. stated that the claimant , together with , purchased this building in August of 1977 from and have been in the process of developing a mall on the premises.

This source stated that the claimant has opened up a store, a _____ store, in this small mall next door, and that the business is called, _____. He stated that the business had been open for the past one month and the claimant herself is operating it.

_____ does not operate the retail business but is involved in developing the mall. He stated that they have hired the work done on the premises and are not doing any physical construction work themselves. This source stated that the claimant has been around during the developing of this mall, and works in a supervisory capacity since August, but since they opened the business a month ago, she has been working full time doing retail sales work and that she is in every day. This source stated that he has cut her hair frequently and, for that matter, had been in earlier that day. He stated that the claimant complained of not feeling too well because of the damp weather, this being December 15th, and that she complained of headaches and her neck bothering her. This source stated that she has been wearing a cervical collar continuously since this accident and has also been using a cane to get around as her leg has been bothering her. This source stated that he recalled possibly a couple of weeks ago, that the subject, while walking across the street, fell when her leg gave out on her. He stated that she seems to be having a lot of trouble and is apparently receiving therapy treatments at this time. He stated that he is quite sure she is having some legitimate problems. He was unaware of any previous health problems prior to this injury. He stated that he has no idea what income she would be receiving and stated that she is a partner in the development of this mall, along with _____. He stated that he had no idea where they are living but is aware of the relationship.

We have learned that Mr. _____, through city directories, is _____ shown to be residing at _____ and that his wife's name is _____ and employed with _____.

Mrs. ,
Windsor, Ont.

Mrs. stated that she did not know the claimant, , was aware that there was a residing across the street, and that there seemed to be a lot of people coming and going from that residence. She stated that apparently these people moved out in the spring and she has no idea where they are living now. She suggested that perhaps , next door, might know more about the situation.

Mrs. ,
Windsor, Ont.

Mrs. stated that Mr. moved out of the house back in the spring, possibly around April, and that she has no idea where he moved to. She stated that he had been living there, along with his wife and children. She stated that there had been an exceptional amount of traffic coming and going from that residence and that the police have been around on several occasions. She stated that she suspected that they may have been dealing with drugs but she has no first hand knowledge of this and that it is only a supposition on her part. She stated that there certainly was an abnormal amount of traffic coming and going from the residence. She stated that she did not know a and was not aware of her living here.

Confidential Source,
Bondy, Kirwin Law Firm,
Windsor, Ont.

This source stated that she did not know , but had knowledge of Mr. , known as . She stated that he has been involved in illegal activities and has a very poor class of associates. She stated that he had been employed with and that he is presently developing a on . She stated that he is the kind of person who, if you want somebody beaten up, you have only to contact him and he will look after it. She stated that she has also been aware that he has been involved in drugs and

at one time, a few years ago, had been in jail in Kingston on drug charges, going back to about 1971 or 1972. She also stated that she is aware that he is associated with , and who are well known in the area for their illegal activities. This source stated that he also has another friend who operates , who would be the brother of , probably, who has illegal connections as well. This source stated that she had no knowledge of the claimant herself.

Mr. ,
Windsor, Ont.

Mr. stated that he did not know the claimant, , but certainly knew of and that, as a matter of fact, he had been into the law firm this past summer in connection with an accident in which and some other of his friends had been injured and the whole thing is very questionable. He stated that he has not run into but due to the fact that she is just around the corner from them, he would try to keep an eye on her and, in fact, would check through their records to see if there had been any indication of having been injured in the aforementioned accident, in which was apparently involved. As of this writing, he has not contacted us, however we will send a follow-up memorandum when we hear from him.

As per our telephone conversation of December 15, 1977 we are closing our handling at this time.

Yours very truly,

John F. Todd.

JFT/w
Trip.

Bill called, no indication of previous accident. Poss. living at .

The second example arose out of a motor vehicle collision on May 15, 1972, in which the claimant was injured. The injuries were caused by the negligence of a person insured by the Greater American Insurance Company. That company instructed Jolie & Todd Investigations to carry out an investigation. The resulting report read as follows:

JOLIE & TODD INVESTIGATIONS
CLAIM INVESTIGATIONS
Telephone 254-2723

REQUESTING CO.
Great American Insurance Co.
60 Yonge St.,
Toronto, Ont.
Date June 20, 1974.

NAME OF REQUESTOR [name supplied]
Claim No. 70660
Assured Murphy Tobacco Co.
REPORT ON: ,
 Windsor, Ont.
 (Not ,
 Windsor, Ont.)
AGE: years

NATURE OF INVESTIGATION:
Date of Accident - May 15, 1972
Nature of Injuries - Back, neck, etc.
Claimant is represented by Brian Pape. This investigation conducted as required in our telephone conversation of June 13, 1974 and covers an investigation made June 14, 17 and 18, 1974.

SUMMARY

RESULTS:

is years of age and is married to , born , who is employed as a repairman with the Ford Motor Company of Canada. His income is in the area of \$10-11,000. a year. They have been at the present address, in Windsor, Ontario since August 1972 when they bought this small frame house for \$12,500, paying \$1,200. down. They formerly lived at

for a short period of time and apparently she had arrived in the country a short time prior to marrying . She is and he is . He himself had formerly lived for a short time at , Windsor, Ontario and at . They have been in the Windsor area since around 1966.

They have a good credit record locally and we learn of no financial trouble at all. He deals with the Canadian Imperial Bank of Commerce, Devonshire Mall Branch, has borrowed here and has a good repayment record. We learn of no writs, suits or judgments.

is a practical nurse and started working for Riverview Hospital of 3177 Riverside Drive East on April 17, 1972. She went off work May 3, 1972 at 1:15 P.M. as she was not feeling good. She then went in to I.O.D.E. Hospital, also known as Windsor Western Hospital on May 8, 1972, was confined here until May 10, 1972 when a D & C was performed. She was then under the care of a Dr. S and apparently she went in at this time, due to infertility.

Claimant had not returned to work when apparently she was involved in an accident May 15, 1972 in which she supposedly suffered back, neck injuries, etc. This apparently hospitalized her at that time.

As a result of this accident she never did return to work and was taken off the staff due to illness of an indefinite term. She was never fired or laid off here and would have been eligible to return as soon as she could show physical fitness and ability to carry on her normal duties. They have not heard from her since that time and have no idea what has transpired since. Their records indicate that she was in Metropolitan Hospital for a period of time, however the exact dates are not available.

The claimant would not have been eligible for any S and A benefits from Riverview

Hospital due to the fact that she has not completed 60 working days.

At the time she started there, she was making \$422. a month, the contract date being May 1972. As of May 1973 her income would have been \$439. a month and as of May 1974 it would have gone to \$474. a month.

There is nothing in hospital records to indicate that this woman had any pre-existing back or neck conditions. She was however, there for only a short period of time and they never did get to know her too well.

The claimant was then off until on or about 9-19-73 when she started working as a practical nurse for one , operating [nursing agency], [address], Ontario. She worked as a practical nurse, doing private duty nursing, at the rate of \$2.73 an hour. This rate just went up to \$2.86 an hour. She has been working an average of 3 days a week, 8 hours a day.

Dr. S is no longer in practice in the Windsor area however was associated with Dr. D of [address] here in Windsor when he did practice here, and Dr. D has taken over the claimant as a patient. Dr. D apparently has this woman's background. It is interesting to note that he sent in a medical report to [nursing agency] and this was dated 9-19-73, to the effect that this woman was in good physical condition, however Mrs. indicates that Dr. D was aware of the claimant having had an accident as apparently he had sent this woman to the hospital for a brain scan and was aware of the accident. He did however, give her a clean bill of health although it is apparent that this claimant is still having some problems. We have been unable to establish whether these problems are completely related to the accident or whether they have something to do with some preexisting condition or a condition which has cropped up since the accident. The claimant has been suffering general weak spells, pain in the

head, has had a couple of episodes of throwing up. She had a brain scan done in March or April, 1974, and right around this time had some blood work done also. The claimant has bad eyes and apparently has had this condition for some time, wears fairly thick lens glasses.

Following the accident, CIAG paid this woman \$2,814. S and A Benefits covering 40 weeks and 1 day. The local office, however, does not have the medical records supporting her claim, these being in their London office. It was thought originally that the claimant had gone to I.O.D.E. Hospital for brain scans however apparently this was done at Metropolitan Hospital. She was at I.O.D.E. Hospital for the D and C however.

It is interesting to note that residential neighbours at both the present and former address have been unaware that the claimant has anything wrong with her at all. Her activities appear to neighbours to be normal for a woman of her age and state of life. Her husband has been subject to fairly frequent layoffs from Ford Motor Company due to lack of seniority and this is felt to be the main reason why the claimant has worked in the past.

The claimant received her practical nurse's training at the . A report from this hospital indicates that the claimant attended there 5-1-70 to 8-3-71, that in this period she missed 39 days due to sickness while in training. The nature of this illness is not stated, however. She had a good record as to being capable and efficient, although there was some doubt as to whether she could advance to supervisory ranks. This claimant's maiden name was and she trained under this name at .

As far as her activities are concerned, she and her husband go out socially on occasion, seem to have very few close friends, are not active in sporting activities or anything of this nature. She is seen occasionally

puttering around the yard but neither she nor her husband appear to be too interested in keeping up the outside of the house and he will merely cut the grass on occasion, doing little weeding or anything of this nature. They have a dog of their own and at the present time are looking after a friend's dog also. As stated, resident neighbours at both address were unaware that she had ever had anything wrong with her, had never noticed a sign of disability on her part, however she and her husband have never been the type to associate with neighbours, will say hello and comment on the weather, but this is about the extent of any contact they have with resident neighbours.

This inspector had occasion to interview the claimant indirectly at 11:40 a.m., Monday, June 17, 1974. She is a woman approximately in height, , has . At this time she was wearing a yellow top and slacks. She had a dog, about 30 lbs. which was on the front porch and prior to opening the front door, she stooped over and picked up this dog and carried it in her arms during the course of our interview, which took approximately 5 minutes. She had no trouble picking up the dog and holding it during the course of our conversation. In this period, she was noted to look to the right and the left, had no apparent stiffness or soreness in any of her movements. She does give the impression of a perfectly normal person.

INVESTIGATION

Credit Bureau records were checked for background and show mainly a record on whose date of birth is . His wife is known as and there is no indication in credit bureau records that she has ever worked. He has been on file locally since 1966 and shows as starting with the Ford Motor Company in August 1970. Their records indicate that he bought the house at , Windsor, Ontario in August 1972, paid \$12,500. for this property with \$1,200.

down. He has former addresses of , Windsor, Ontario , and . They deal with the Canadian Imperial Bank of Commerce in the Devonshire Mall, who registered a chattel of \$4,291.20 in 1972. All trade is good and there is no record of any writs, suits or judgments. He also comes from .

Mrs. W,

,
Riverview Hospital,
3177 Riverside Dr. E.,
Windsor, Ont.

This source did not have records available herself, however indicated that the claimant worked from April 1972 until on or about May 15, 1972 when she left of her own accord. She was still on her probationary period at this time, was working as a nursing assistant, had a good record for the short period there. She would be eligible for rehire. Mrs. W did not have further information available and suggested we return at a later date to interview her secretary who would have more information.

Mrs. ,
Windsor, Ont.

Stated that the claimant and her husband have lived next door for approximately two years, that they are a young married couple, have no children. They have a small to medium sized dog. As far as this source knows they are buying the house here. She stated that he is a Ford man and she believes that the claimant is a nurse of some kind as she sees her in a white uniform from time to time on an irregular basis. Mrs.

stated that the claimant has always appeared healthy to her, has not shown any sign of disability in the two years that she has lived next door. The claimant appears to be able to do her housework and to come and go pretty well as she pleases. She has never known anyone to come in and help her housework. She did state that these people are friendly enough but just aren't social in

that they will go out of their way to talk to neighbours.

Mrs. ,
Windsor, Ont.

Basically confirmed the information given by [redacted] and stated that she was unaware that the claimant has had anything wrong with her. She has never noted any sign of disability or frailty on her part. She knows that they bought the house next door a couple of years ago, that he is [redacted] and she is [redacted]. She has seen both of them doing a little bit of work around the yard but indicated that neither seems to be the gardening type and will do minimal work only. They will cut the lawn but will not trim around the edges and things of this nature. She seems to confine her activities to within the house for the most part.

At this point, namely on Monday June 17, 1974, at 11:40 A.M., we did interview the claimant indirectly and obtained the information previously given.

We then interviewed two neighbours at the former address, a Mrs. [redacted] at [redacted] and a Mrs. [redacted], at [redacted], who recalled that the claimant and her husband had lived at [redacted] for a short period of time. This house had been bought by a young Irish fellow who kept one room and allowed them to use the rest of the house. They lived here for a period of time until they bought their house at [redacted]. The owner of this house at [redacted] would probably have known them best, but has himself gone back to Ireland. They did not get to know the claimant well at this address, knew nothing of an accident or injury, had never known her to be laid up at all.

We then interviewed a Mrs. Joan Wiede, Adjuster with CIAG at 110 Tecumseh Road East, Windsor, Ontario, however they had no record of this claim, stated that their S and A benefits are handled out of their regional London office however she was able to check with them and learned that they

paid this woman a total of \$2,814. covering 40 weeks and 1 day, as she was apparently whiplashed in an accident and was getting therapy. She was receiving benefits at the rate of \$70. a week. No further information was available here.

Mr. [redacted] of the Canadian Imperial Bank of Commerce, Devonshire Mall, confirmed that Mr. [redacted] has been a customer there for several years, did confirm the loan, stated that his repayment record is excellent, that he maintains an account here and there is no problem with it at all. He could not comment on the claimant herself, did not know her. No further information was available here.

As Mrs. [redacted] had indicated that she had seen the claimant in what appeared to be a nurse's uniform, we decided to make a search of various nursing registries in the Windsor area and finally did find that the claimant was working for the [nursing agency] at [address], Ontario, this being a suburb of Windsor, approximately 17 miles out of the city.

Mrs. [redacted], Ontario.

Mrs. [redacted] stated that the claimant started working for her on or about 19-9-73 as a practical nurse. Since that time she has been working an average of about 3 days a week, doing private duty nursing through their agency, and being paid \$2.73 an hour until just recently when the rate went up to \$2.86 an hour. She is working an 8 hour day here. She has been found to be co-operative, gets along well with people and is considered somewhat outstanding as a practical nurse. Mrs. [redacted] stated that she has received a medical from Dr. D. of [redacted] dated 19-9-73, to the effect that this woman had a good health record and indicated that everything was negative inclusive urinalysis, blood tests, etc., and also indicated that this woman had no back trouble or anything of this nature at this time. It is

rather strange, however, as Mrs. was quite sure that Dr. D has been looking after this woman subsequent to the car accident. She does know that Dr. D sent this woman for a brain scan and this occurred around March or April of this year. Also at this time, he sent this woman for a series of blood tests. Mrs. thought that the doctor had sent the claimant to I.O.D.E. Hospital for this brain scan. There is some question in our mind, and also that of Mrs. , that the claimant's problems at the present time and since the accident, are totally related to the accident as the blood work is not felt to have anything to do with an accident. The claimant, since working for , has on occasion suffered weak spells, pain in the head and petered out as the day went on, and has thrown up on a number of occasions. Some of this problem may be related to this accident but there is some question as to whether she may be having other problems as well. This source then went on to say that prior to hiring the claimant, she went back to where the claimant was trained at the , and received a letter from a , the principal of that School. Mr. stated that the claimant who was then known as had attended the school of nursing from 5-1-70 to 8-3-71, that she had a good record, was found capable and efficient although there was some question that she would be able to assume supervisory duties. There was also an indication that in this period, the claimant missed 39 days due to health, although the nature of this health problem was not indicated. There was a note later on that they did not know of any reason why she would not, healthwise, be able to do her job. The claimant has indicated to Mrs. that she was not taking full time work due to her accident, and due to the fact that she just could not handle it. Her application shows that she has not worked since Riverview Hospital and gave her reason for leaving Riverview Hospital as illness.

Mrs. M,
Department,
Riverview, Hospital,
3177 Riverside Dr. E.,
Windsor, Ont.

Stated that the claimant started with them on April 17, 1972 and worked as a nurse's aid. She then notes that the claimant went off duty officially May 29, 1972 however upon checking further, the last payday was May 7, which indicates a discrepancy here. She therefore checked further and showed that the claimant's last day of work was May 3, 1972 at which time she went off due to illness. Later, they received a slip to the effect that she went off on an indefinite illness effective May 29, 1972. Due to the short time there, the claimant was not eligible for S and A benefits, as they have to work there for 60 full days prior to becoming eligible. This source did not have any further information and suggested that we go back to the nursing office.

Mrs. M,

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Riverview Hospital,
3177 Riverside Dr. E.,
Windsor, Ont.

Confirmed the information previously given and stated that the salary schedule for nursing assistants is as follows: as of May 1972, \$422. a month; as of May 1973 \$439. a month; and as of May 1974, \$474. a month which is based on 21 working days a month, and 8 hour days. She stated that their records show that the claimant last worked on May 3, 1972 when she went off work at 1:15 P.M. as she was sick. The exact nature of her illness was not shown, however their records then indicate that the claimant went into Metropolitan Hospital for a D and C on May 8, 1972. There is, following this, a notation that she had a car accident and was suffering from shock and had been going for therapy. The record also shows that she was admitted to Metropolitan Hospital on May 29. The doctor is not shown. This source then

went on to say that the claimant was not fired or let go, that in a situation of this type an employee goes off indefinitely and is taken off the rolls until she indicates a willingness to return to work and shows physical proof of being able to carry on the normal duties of her job. This must be supplied by her family doctor. Her work entailed working with elderly and infirm people and involves quite a bit of lifting of patients and moving them about and does include quite a bit of strenuous work. Claimant's record prior to May 3 was good, although she had only been with them for a short period of time.

We then checked with I.O.D.E. Hospital records here in Windsor and learned that the claimant was confined there from May 8 to 10, 1972, due to infertility when a D and C was performed on her by Dr. S. They have no record of her having been in for any other reason.

Dr. S is not listed in local telephone listings, etc. however we did recall that Dr. S was affiliated with Dr. D of [address]. We therefore checked with Dr. D's office and confirmed that Dr. S formerly looked after this woman and that she is now under the care of Dr. D. They would, however, give no information out on the claimant without medical authorization.

We then checked with Metropolitan Hospital but could not come up with anything of a concrete nature there. We have a source who is still trying to get information from this location, and should it become available to us, it will immediately be passed on to you.

We also checked with the Windsor Police Department in an effort to determine whether the claimant might have been involved in any

other car accidents but came up with negative results.

Yours very truly,

George J. Jolie.

GJJ/w

Dup.

NOTE:

We have approached the limits set by you in this investigation and are not handling further. However, should any further information come to our attention, particularly from a confidential source at Metropolitan Hospital, it will be forwarded on to you. Should you wish us to make further inquiries on your behalf in this area, please do not hesitate to call or write me.

There were tendered in evidence 212 investigation reports requested by clients of Jolie & Todd Investigations. Each report contained confidential health information obtained without the claimant's consent. The evidence is clear that Jolie & Todd Investigations were instructed by their customers to seek this type of information. The customers were adjusting firms carrying on business in the City of Windsor and insurance companies. The adjusting firms were: Windsor Adjusting Company Ltd., S.C. White Adjusters Ltd., Statham-Pope Ltd., T.G. Hall Insurance Adjusting Ltd., McPherson Adjusting Service Ltd., Helwig Adjusting Co. Ltd., and J.W. Foley Insurance Adjusting Ltd. These companies employed a total of 16 adjusters in the Essex County area.

Mr. Robert Hogarth, President of Windsor Adjusting Company Ltd., and an adjuster with 28 years experience, was designated to appear before me by each of these companies except Statham-Pope Ltd., which was inactive at the time of our hearings. Mr. Hogarth said that he had spoken to Barney Statham of Statham-Pope Ltd. and that Mr. Statham had told him that he "did not disagree with the position that the fellow adjusters are taking". Mr. Hogarth testified on behalf of these companies, the 15 adjusters and himself, that:

1. it had been an accepted practice in the insurance industry for at least 28 years, to seek confidential medical and

health information about the claimants without their authorization;

2. independent adjusters are always specifically instructed to retain investigators although, on occasion, they may suggest to an insurance company who is their principal, that such an investigation be undertaken;
3. the cost of an investigation is always paid by the insurance company as a disbursement;
4. none of the adjusters, on whose behalf he was speaking, nor any of their employees, had approached a physician or hospital in Essex County since they were all aware that physicians and hospitals would not provide confidential health information without authorization;
5. it is improper to instruct an investigator to attempt to obtain health information from a physician, hospital, or hospital employee without the claimant's authorization;
6. hospital and hospital employees, physicians and physicians' employees have an obligation to keep the contents of health records confidential and this principle of confidentiality is, and was, a subsisting and recognized principle;
7. the adjusters knew or ought to have known that this principle existed and ought to have recognized and accepted it;
8. the adjusters, in the course of their duties, usually on the express instructions of their clients who were insurance companies, directed Jolie & Todd Investigations and Equifax Services Ltd. to carry out investigations knowing that investigators, from time to time, during these investigations, would

obtain confidential health information from hospitals and physicians without the consent of the patient;

9. investigation reports containing confidential medical information from doctors and hospitals were received from time to time by adjusters in the course of their duties and used in the evaluation of claims;
10. these reports were always delivered to their clients' insurance companies;
11. the private investigators ought not to have been retained for the purposes of obtaining medical information because the obtaining of this information without patient consent violated the principle of confidentiality;
12. all of the corporations and individuals on whose behalf he was speaking accepted, as a matter of policy, that confidential health information ought not to be sought or received by adjusters, their servants or agents, or investigators without the patients' prior consent;
13. as a matter of policy, the adjusters accepted the principle of confidentiality and in the future would refuse to follow any instructions that might be given by an insurance company to instruct investigators to obtain confidential medical information without authorization, even if the refusal resulted in the adjuster losing that insurance company as a client.

I found Mr. Hogarth to be frank and forthright. It was his opinion, and I accept it as a fact, that the instructing of investigators to obtain confidential health information had been a practice carried on for at least 28 years without any thought whatsoever. It was his view that little, if any, benefit had been gained by the practice and that, on balance, the reports had not been worth the money spent for them.

The companies listed below were clients of Jolie & Todd which had received investigation reports obtaining confidential health information obtained without patient consent. It is clear from the documents in evidence that Jolie & Todd Investigations had been instructed by their customers to seek this information. I believe that all of these companies and their employees knew, or ought to have known, that hospitals, hospital employees, physicians and their employees had an obligation to keep the contents of the health records of their patients confidential. They instructed Jolie & Todd Investigations to carry out investigations when they knew or ought to have known that, during these investigations, Jolie & Todd Investigations and their employee, Mr. Stickley, would attempt to obtain confidential health information without the consent of the claimants. They ought not to have done this. They are:

Fireman's Fund Insurance Co.

The Co-operators

Lumbermens Mutual Casualty Company Ltd.

Shaw & Begg

State Farm Insurance Co.

The Hartford

Allstate Insurance Company

Royal Insurance Company Limited and the corporations encompassed by the Royal Insurance Group

Northland-Crawford Insurance Co.

Commercial Union Assurance Company

Underwriter's Adjustment Bureau (adjusters)

Zurich Insurance Company

United States Fire and Guaranty

(otherwise known as U.S.F. & G.)

I accept the evidence of Mr. Jolie and Mr. Todd that neither their employee, Mr. Stickley, nor they themselves ever misrepresented themselves as physicians, health-care personnel or OHIP employees. But other conduct engaged in, and which I shall describe in some detail, was as indefensible as any disclosed throughout our hearings.

At least five investigation reports prepared by Jolie & Todd Investigations in which confidential health information had been obtained from a confidential source at Metropolitan Hospital, Windsor, were placed in evidence. Portions of some of these reports read as follows:

We first interviewed a confidential nursing source at Metropolitan Hospital who verified that she recalls the subject was

hospitalized just before Christmas in this injury and that as far as she recalls he did receive a fractured pelvis. She stated that this injury did not require any pin placement and that it healed on its own. She stated that he was able to get out of bed while he was in the hospital and recalled that he had gone home just prior to Christmas. He was then required to stay in bed for a few days at home. She stated that she could not recall the name of the doctor but thought possibly it may have been Dr. K or or a specialist. This source also stated that he did have a large bruise on his hip but was able to get around quite well. She stated that she did not recall the subject ever returning to the hospital. She stated that he did appear to be a big boy for his age and as far as she knew there had been no previous injuries or health problems.

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This source stated that she recalled that Mr. [redacted] had received a broken femur, thought it was the left leg and that he had also had a possible broken wrist and a possible back injury. She stated that he had seemed to be in a lot of pain when he came to the hospital and that he was confined there for quite a period of time, possibly up until the end of the year. She stated that there seemed to be some complication with his leg and that she had no idea how he is coming along at this time. She stated that the wife was also admitted for about 3 or 4 days, and had had some cuts and bruises and possible abdominal injury because she had been wearing a seat belt at the time and had been confined for observation. This source stated that she also heard that the daughter, [redacted], may have received an injury because of the seat belt, and that she had cuts and bruises but did not believe there were any stitches. She stated that she had been hospitalized for a few days for observation, as far as she knew. She stated that the daughter, who is about 12 years of age, had a broken leg and she understood that

this child was confined to the hospital for some time. Also, there was an older child, about 15, who was hospitalized at Hotel Dieu. This source stated that she did not really know just what injuries this child had received or what her condition was. She stated that she did not recall how long Mr. [redacted] was confined to the hospital exactly, but understood that he had a broken left femur that he was in traction for a time. She stated that she was aware that the wife is a step-mother to the children and did not know what had happened to the claimant's first wife.

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This source stated that the boy was admitted to hospital on February 3, 1974 and that he was confined to the hospital for a period of 10 days.

This source stated that the boy was operated on by Dr. I, an eye specialist, who maintains his office on [address]. This source stated that she had actually cared for the boy and observed the broken toy as the family had brought it to the hospital to show the staff. She stated that it is a round cylinder type, red in colour, and part of it was broken off and appeared to be somewhat of a half-moon shape. She stated that the eye was cut and Dr. I had put several stitches in the eye to sew it up. She stated that the boy was hospitalized for about 10 days. She stated that he had lost permanent sight in this eye and the eye was cut right across the cornea and that she had observed this when the doctor removed the bandage. She stated that the white part of the eye was bloodshot and observed the sutures in the cornea. She stated that the boy could not determine light from dark in that eye and that it appeared to be a permanent injury with no probability of regaining sight. This source stated that other than the eye injury, there were no other health problems and, as far as she could tell, the boy seemed to be adjusting

to the situation. She stated that she did not know how the boy was brought into the hospital. They have attempted to obtain medical records through confidential sources at this hospital, but we have been unable to obtain these records, unless we first receive medical authorization from the family.

• • • •

The claimant is known to have been treated and released from Metropolitan Hospital as a result of this fall. Confidential sources indicated that she was treated by a Dr. J and her family doctor is Dr. R. There were no x-rays taken, apparently she was sent home after being looked at, and given pain pills. It is understood that the injury occurred around 11:45 P.M. and that she did not come to the hospital until 1 A.M. and then came by ambulance. We learned here that the address was given of . She is known to be under the care of her family doctor, Dr. R and is thought to be taking physiotherapy treatment, however we have not been able to learn just where without medical authorizations.... We next checked with a confidential source at Metropolitan Hospital and learned that the claimant was treated on September 30, 1977 and that she had an injury to her sacrum and was treated by Dr. J at the Emergency Department. Record here shows her family doctor to be Dr. R. There were no x-rays taken and she was sent home with pain pills. She was injured at 11:45 P.M. and came to the hospital at 1 A.M. by ambulance. Records shows her address as . This information is to be kept in strictest confidence as it is through a confidential source.

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Medical records at Metropolitan Hospital were checked and we learned that the subject was confined there in the period April 8 to 18, 1975, and was under the care of Dr. J here in Windsor.

Throughout this report, I have pointed out that many investigators equated an anonymous source who provided information in response to a pretext with a confidential source which was a known person, who, because of a relationship with an investigator, provided information. Mr. Todd truly had a confidential source at Metropolitan Hospital.

In accordance with the procedure followed throughout the hearings, and upon learning that he must do so, Mr. Todd reluctantly wrote the name of the confidential source on a piece of paper which was marked and treated as a sealed exhibit until the person named had been notified and given the opportunity to be present, either personally or by counsel, and participate in the hearings. Mr. Todd named his wife, Joan Barbara Todd, as his confidential source.

Mrs. Todd appeared, with counsel, and gave evidence. She is a registered nurse and has practised her profession since 1963. She was employed at Metropolitan Hospital on a full-time basis during the period of May 1965 to April 1966, and on a part-time basis from September 30, 1968, to July 12, 1976, in the paediatrics department. On July 13, 1976, in accordance with a request made by her, she was transferred to the emergency department of Metropolitan Hospital and was employed in that department from July 13, 1976, until the date of our hearings in August, 1978. I accept Mrs. Todd's evidence that she did not request a transfer to the emergency department to be in a better position to help her husband by having personal contact with some accident victims and access to the records kept in the emergency department.

Mrs. Todd was always aware that, as an employee of Metropolitan Hospital, she had an obligation to abide by the written hospital policy, of which she had actual knowledge, that no information about a patient would be released to an adjuster, insurer or investigator, without the patient's written authorization. She also knew that, as a registered nurse, it was her professional obligation to keep confidential all information about every patient. In fact, she advised her husband of these obligations. Despite this advice and his actual knowledge of his wife's obligations, in 1972, he began to ask her questions about patients who had attended at Metropolitan Hospital. At first she refused to give him any information. He kept at her. He was upset when she refused to divulge any information; he subjected her to pressure, and she finally relented. He told her that because he was only seeking the truth, it would not hurt the patient. She believed him, although her professional

training ought to have told her that this was faulty reasoning. She provided confidential health information to him on approximately 10 occasions. She did not know that, from time to time, this information found its way into reports prepared by Mr. Jolie and Mr. Stickley.

In the emergency department of Metropolitan Hospital there was a file drawer in which the emergency records were kept alphabetically for about two months, after which they were removed to the medical records department. Everyone in the emergency department had access to this drawer. On a few occasions Mrs. Todd obtained information from this drawer for Mr. Todd. On other occasions, she was able to tell him what treatment the patient had had because she had taken part in that treatment. She never sought information from the Medical Records Department for Mr. Todd. Mrs. Todd ought not to have given this information to her husband. It was wrong for her to do so and she knew it was wrong when she did it. However, Mr. Todd's conduct in inducing his wife to breach her obligation was unforgivable. He ought to have respected her obligations as an employee and as a professional person and ought not to have exercised his influence over her to induce her to breach these obligations.

Throughout the hearings, I expressed the opinion that hospitals and other institutions ought to be concerned with the future and that the evidence which I heard ought to be used to formulate policies to ensure that breaches of confidentiality no longer took place. In Windsor I asked that Mrs. Todd not be made a scapegoat. Despite my request Metropolitan Hospital chose to discharge Mrs. Todd. Her union grieved the dismissal and the matter ultimately proceeded to arbitration. The board of arbitration was composed of P. John Brunner, chairman, James N. Bartlet, Q.C., hospital nominee, and Chris G. Paliare, association nominee. Both the award of the majority and the dissent reviewed the evidence as to disclosure and concluded that Mrs. Todd had disclosed information in unauthorized circumstances and was guilty of misconduct and in breach of her duty to her employer for which she might be disciplined. The board of arbitration was concerned with the question whether discharge was the appropriate penalty. The decision was not unanimous on the issue of penalty. The chairman and Mr. Bartlet decided that a suspension from August 31, 1978, to May 9, 1979, should be substituted for discharge. I set out their decision on this issue:

However that is not the end of the matter as Counsel for the Union seeks to invoke the provisions of Section 37(8) of The Labour

Relations Act and asks us to substitute another penalty for that of discharge. It is submitted that the grievor has been an exemplary employee for some ten years, has no disciplinary record and as referred to during the course of the hearings, possesses above average Nursing skills. It is said that she has learned her lesson as a result of her as well as her husband's involvement before the Krever Commission at its hearings in Windsor. It is said further that but for the hearings of the Commission, and the revelations made thereat, the grievor's misconduct and breach of duty would not have been dealt with so harshly by the Hospital. It is suggested that she is being made the scapegoat for the misdeeds of others, who have from time to time acted in breach of The Public Hospitals Act and its Regulations. We are told that this is the first time in this Province that a Staff Nurse has been discharged from her employment for this type of conduct.

On the side of the Employer, it is pointed out that the grievor's misconduct and breach of duty was of a most serious nature. It has reflected adversely on the reputation of the Hospital. Members of the Medical and Nursing Staff it is said, do not want to work with a person who "leaks" confidential patient information. Fear is expressed that Mrs. Todd will repeat her misdeeds if she is reinstated. The employer-employee relationship, it is suggested, has been irreparably damaged.

This aspect of the matter has given us a great deal of difficulty. Not without some hesitation, we have concluded that the appropriate order in this case is to substitute a suspension from August 31, 1978 to May 9, 1979, in place of the discharge. We view that to be the just and reasonable penalty in all the circumstances. It should be noted that the Collective Agreement herein does not contain a specific penalty for the infraction that is the subject matter of this arbitration and accordingly

we have the power to make the above order, under Section 37(8) of The Labour Relations Act. In reaching this conclusion, we have taken into account the submissions of both Counsel as above-outlined and as contained in more expanded form in the written arguments each has filed. In our view, regard must be had to the plain but regrettable fact as disclosed by the public hearings of the Krever Commission, that unjustifiable and indeed illegal disclosures of confidential information have taken place on a rather regular basis for a long period of time in this Province. The Commissioner himself has expressed the wish that no one be made the scapegoat for the misdeeds of so many. This is the first time, as far as we know, that a Staff Nurse has been discharged by a Hospital for these reasons. Although the misconduct and breach of duty in question was serious, these truths cannot be ignored. The grievor has been a most satisfactory employee for over ten years until the matters came to light as a result of the work of the Krever Commission. While the Hospital did not in any way act arbitrarily or improperly in reaching its decision to discharge the grievor, it is in our view, most doubtful whether but for the Commission hearings, the disciplinary response would have been the same. Our impression is that the grievor is unlikely to repeat her past misconduct. We are not satisfied that the employer-employee relationship cannot be satisfactorily restored if the grievor is reinstated to her prior position. Weighing all these matters and having given the matter most anxious consideration, we are of the view, that the grievance must be allowed, the discharge set aside and the grievor reinstated to her employment with the Hospital effective May 10, 1979. As indicated, a suspension from August 31, 1978 to May 9, 1979 is substituted but without pay or any other compensation and without accrual of seniority. Subsequent to the hearings herein, we were advised that the grievor's certificate had been suspended by the Discipline Committee of the College of

Nurses of Ontario pursuant to the provisions of The Health Discipline Act, 1974 until May 9, 1979. It is for this reason that our order of reinstatement is not to take effect until May 10, 1979.

Mr. Paliare dissented on the issue of penalty and would have substituted a reprimand for the penalty of discharge. This was Mr. Paliare's opinion on this issue:

In my view, the only just penalty that should have been imposed upon Mrs. Todd was a reprimand. There are a number of reasons why I have reached this conclusion.

First, the purpose of discipline should be corrective. The Board has reached the conclusion that Mrs. Todd would not engage in this form of conduct again. Thus, a reprimand on her record would have achieved the desired effect of making it clear to Mrs. Todd that this type of conduct would not be tolerated in the future.

Secondly, the employer did not have any rule, express or tacit, that the disclosure of confidential information by a nurse would result in automatic discharge. Fairness dictates that if a particular type of misconduct will result in discharge, that fact should be clearly brought home to the employees so that they understand the risk they run when they engage in that particular type of misconduct. It was obvious from the evidence that Mrs. Todd never realized that by providing her husband with this information, she ran the risk of discharge. Her conclusion in that regard was based on her observation that she was not providing her husband with any information other than the type which was often provided by the Hospital to the news media. Hospital witnesses agreed that this type of information was often provided to the media, although the Hospital did have regular and specific channels for the dissemination of that type of information.

Thirdly, we were advised that this was the first time a nurse in this Province had been disciplined for this type of conduct. In my view, I am certain that this type of information has been disseminated by hospital employees throughout the Province on many occasions in the past. However, the Krever Commission has made all members in the health care field much more sensitive and aware of the confidentiality that should attach to patient information. Mrs. Todd should simply not be made a scapegoat because she was discovered doing something that many people in the health care field were doing prior to the Krever Commission.

Fourthly, the evidence before the Krever Commission revealed that both doctors and lawyers had played an active role in encouraging serious, intentional breaches of confidentiality of patient records, all for the sake of the insurance company masters they were serving. The lawyers that were involved included senior members of the Bar who were actively involved in negligence litigation. One of the doctors involved in alleged breaches of confidentiality of patient information was a very senior practitioner in Toronto, who interviewed patients in hospitals wearing his white "doctor's coat" when he did not have privileges in that hospital, nor was he authorized by the patient or the patient's doctor to obtain any information. The evidence revealed that this particular doctor then forwarded the information he obtained to the insurance companies that had hired him to prepare these reports. It is my understanding that the most serious penalty imposed on any of these professionals was a reprimand on the doctor by his licensing body. Accordingly, it appears grossly unfair that the penalty that should be imposed on Mrs. Todd, a nurse, should be so drastically disproportionate to that imposed upon other professionals for the same, or more serious, breaches of confidentiality of patient records.

Finally, we were advised by the Ontario Nurses' Association that the Discipline Committee of the College of Nurses only imposed a penalty of a three-month suspension upon the grievor for the matter which was the subject of this arbitration. It strikes me as odd that a Board of Arbitration would find that the penalty of discharge was appropriate in the same circumstances where a licensing body for a professional group would come to the conclusion that a three-month suspension was appropriate.

In summary, the majority could have satisfied the fundamental principle of corrective discipline by imposing a reprimand upon Mrs. Todd and, in the course of its Award, could have warned that because it was the first case of its kind, nurses in the Province should not assume that future Boards of Arbitration will treat this type of misconduct lightly. I totally agree that breach of confidentiality is a serious matter, but when a Board of Arbitration is charged with the task of determining the "justness" of a penalty, it must enquire into all of the circumstances in arriving at its conclusion. In my view, the circumstances set out above led me to the conclusion that a reprimand would have been the appropriate form of penalty, rather than discharge.

Then, the Board goes on to invoke its statutory authority under s.37(8) of The Ontario Labour Relations Act. In my view, the majority has failed to exercise its jurisdiction properly under that subsection which gives a Board remedial authority. Simply imposing a suspension from the date of the discharge until the date of the Award is not a proper exercise of the Board's statutory power. The grievor and her bargaining agent, the Ontario Nurses' Association, have little power in dictating when a Board of Arbitration will be set up and how long it will take to arrive at its decision. In this case, it took slightly

more than four months before the Board of Arbitration could hear the case and the decision of the Board will not be rendered for more than seven months after the discharge. It is simply unfair to the grievor, and contrary to the purpose of s.37(8), to have the Board use the length of time it takes for a Board to arrive at its decision, as a yardstick in determining the appropriateness of a penalty. Rather, the Board, pursuant to s.37(8), should determine on its own what the appropriate penalty should have been in all of the circumstances, and not rely on the date of the Award as a method of avoiding the task imposed upon it by statute. In the circumstances, even if a period of suspension was required, it seems inconceivable to me that the period of time imposed by a Board of Arbitration should be any greater than that imposed by the licensing body of the College of Nurses.

Accordingly, I would have upheld the grievance and imposed upon Mrs. Todd a reprimand setting out clearly that any future acts of misconduct related to the breach of patient information would result in a more serious form of discipline, including discharge.

As indicated in the arbitration award, after Mrs. Todd's activities became known, her conduct became the subject of consideration by the College of Nurses. Her registration was suspended for three months. Mrs. Todd, therefore, was suspended from Metropolitan Hospital for the period of August 31, 1978 to May 9, 1979, and suspended from practice for three months. Although Mrs. Todd's conduct was clearly improper, it was less reprehensible than that of Dr. Porter which I have previously described. I invite the reader to compare Mrs. Todd's punishment with the reprimand imposed upon Dr. Porter by the Discipline Committee of The College of Physicians and Surgeons of Ontario.

All public hospitals in Ontario are governed by boards elected or appointed in accordance with the authority under which they were created. The board of Metropolitan General Hospital has an obligation not to permit any person to remove, inspect or receive information from its medical records except under specified circumstances as set out in section 48 of Regulation 729 (as amended by O. Reg. 193/72, section 1 and O. Reg.

100/74, section 10) under The Public Hospitals Act, R.S.O. 1970, chapter 378, as amended by S.O. 1972, chapter 90.

In these inflationary times, every hospital in Ontario is operated within increasingly restricted budgetary limits and every board must allocate the monies available as wisely as it can. A hospital board need only take reasonable measures to meet its obligations to protect the confidentiality of medical records. It would be unreasonable to require it to set up an elaborate security system which anticipates and protects against every conceivable and imaginary risk of access, however remote. To do so would be a misallocation of resources, and could well impair the hospital's ability to make available to the public essential health services of high quality.

Members of the nursing profession have a duty to respect the confidentiality of their patients' health information. Nurses also have an obligation to refrain from any act which would circumvent a hospital board's efforts to protect the confidentiality of their medical records. Surely the board of every hospital has the right to rely upon the integrity of members of its nursing staff and to assume that every nurse will abide by his or her responsibility and refrain from conduct which would lead to the failure to protect the security of medical records contemplated by the legislation.

Mrs. Todd violated the confidentiality of the health records of Metropolitan General Hospital. I have concluded that, with respect to Mrs. Todd's conduct, the board of Metropolitan General Hospital and its employees acted reasonably and properly in its attempts to preserve the confidentiality of their medical records. The records were improperly inspected, not because of any deficiency in security, but because of Mrs. Todd's deliberate invasion. The activities, practices and conduct of the board of Metropolitan General Hospital, in so far as Mrs. Todd's behaviour was concerned, were, in my opinion, beyond criticism.

The investigation reports of Jolie & Todd Investigations indicate that information was obtained from Metropolitan General Hospital from sources other than Mrs. Todd, from Windsor Western Hospital, I.O.D.E. Unit, and from Hotel Dieu of St. Joseph's Hospital. Although information was clearly obtained from each of these hospitals, the disclosures were in response to pretexts. When a pretext is used, in my judgment, it is difficult to speak of a finding of misconduct on the part of the board of any hospital, or of the health-care person who released the information for, essentially, someone was tricked. That is, however, not to say that better care could not have been taken. Before the creation of this inquiry, a general lack of caution

prevailed, not only in Windsor, but throughout the province, in the health-care field with relation to the issue of confidentiality. I will, in due course, set forth my views of the general attitudes of hospitals and health-care personnel in more detail.

I heard evidence from administrators of these hospitals and from some of their employees. In light of the admissions made by Messrs. Jolie, Todd and Stickley, which confirmed that pretexts had, in fact, been used to extract confidential health information, I need not review the various explanations given. They were to the effect that everyone who released information believed that he or she was aiding a patient in the collection of some pecuniary benefits.

Ford Motor Canada, which I shall call Ford, is a large industrial employer in the County of Essex. I discuss the manner in which health information is obtained and maintained by employers elsewhere in this report in connection with occupational and industrial health records. For present purposes, I need only describe briefly how some health information is handled by Ford.

Ford has a medical department. There are satellite nursing stations strategically located throughout the plant areas. In addition, a hospital is maintained in Windsor in a plant designated as No. 2. The medical records generated at the nursing stations and by virtue of employees' attendances at the hospital are maintained in the hospital area by the physicians employed full time by Ford.

The personnel services department encompasses the sickness and accident section and the workmen's compensation section. The sickness and accident section processes employees' applications for sickness and accident benefits to be paid by an insurer. These applications are made when an employee is absent from work as a result of sickness or an accident that is not an industrial accident. The workmen's compensation section processes employees' applications for workmen's compensation benefits. These application are made by employees who are injured in work-related accidents. This section accepts application forms and physicians' certificates filed in support of the applications, ensures that the forms are properly completed and forwards them to the Workmen's Compensation Board in Toronto. A separate staff administers each section. The workmen's compensation section is located in Plant No. 2, in the hospital area, and its employees work out of the same administrative area as the hospital's administrative staff.

The staff of each section must determine whether an injury is the result of an industrial accident, and thus properly payable by the Workmen's Compensation Board, or whether it was not so caused and therefore properly payable by the sickness and accident insurer. As a result, there is a free flow of health information among the hospital, sickness and accident section, and the workmen's compensation section. Both the sickness and accident section and the workmen's compensation section keep copies of each application for benefits and copies of all physicians' statements and medical reports submitted in support of these applications. In fact, there are six four-drawer filing cabinets indexed alphabetically containing copies of all applications for workmen's compensation records and physicians' documents filed in support. Because the collective agreement requires that Ford pay a workman who is injured in an industrial accident the balance of his shift pay, the personnel in the workmen's compensation section have access to the logs showing the rates of pay for each of Ford's employees.

I have given this outline of the manner in which information is maintained at Ford because Messrs. Jolie, Todd and Stickley had a confidential source at Ford, that is, a known person who, because of his relationship with these investigators, provided them with confidential health information about employees.

In accordance with the procedure followed throughout the hearings, Mr. Todd, Mr. Jolie and Mr. Stickley provided the name of this confidential source by writing his name on a piece of paper which was marked as a sealed exhibit. The person named was notified, advised of the substance of the allegation, and given an opportunity to be present and to participate in the hearings before his name was made public. The confidential source was Edward Fedory, a Ford employee since October 3, 1977, in the workmen's compensation section. Mr. Fedory's position was that of a workmen's compensation administrator. His job was to help Ford's employees in processing their applications for workmen's compensation benefits. He followed up with the physicians, the employee and the Workmen's Compensation Board and truly assisted in the processing of these claims. He had access to the health information in the hospital, the sickness and accident section and the workmen's compensation section.

Mr. Fedory received his early training as an investigator for Retail Credit Company in Detroit, Michigan. In 1972, he began working for a law firm in the City of Windsor, as an investigator, and remained with that firm until 1977. During this period, on behalf of his employer, he occasionally retained Jolie & Todd Investigations to do work for him on a case by case

basis. He was acquainted with Mr. Stickley because of these retainers and also because they had attended university together. Mr. Fedory knew that it was Ford's policy that all information was confidential. Nevertheless, he did, from time to time, give confidential health and other information to Mr. Jolie, Mr. Todd and Mr. Stickley. The exact number of occasions is unclear. Mr. Stickley estimated that he received information on 10 to 12 occasions, but Mr. Fedory thought that number of occasions was considerably smaller, perhaps only two or three occasions. It is unnecessary to resolve this conflict in the evidence and it is sufficient for my purpose to find, on Mr. Fedory's admission, that he knowingly breached his obligations to his employer and delivered confidential health information to these investigators.

The following extract from an investigation report is an example of the type of information received by Mr. Stickley from Mr. Fedory:

Confidential Source

Ford Motor Co.

Windsor, Ontario

The information from this company is most confidential. The claimant has badge # . His family doctor recorded here is Dr. S. He has been absent since the date of the accident, November 16, 1977, and is being paid weekly benefits through London Life Insurance Company in the amount of \$185.00 weekly. These benefits will extend to May 1, 1978, at which time he will go on long term disability benefits. His income is shown as \$7.05 per hour, plus \$.50 cost of living allowance. On record he is described as 5 ft. 6 in. in height and weighs 165 lbs. He was employed as an engine line assembler in Department . There is a history of a fractured left radius, occurring July 29, 1977, at work and he was absent until October 31, 1977. Other than this he has no further health history with this employer.

It was occasionally necessary for him to seek out confidential health information from the sickness and accident section.

Mr. Fedory's position can be no better summarized than in the following answers to several questions put to him:

Q. Did you think you were helping the claimant in giving this information, or did you think there was nothing wrong with giving the information? Tell me why you gave the information out, be it by confirmation or by just telling the information, whatever way it might be?

A. I placed my friendship with this gentleman, and this particular gentleman here, above my loyalty to my employer.

Q. Do I understand you really to say that it is something you realize now you just shouldn't have done?

A. It shouldn't have been done.

Q. It is not something you did generally as your evidence is?

A. No, sir.

Q. You are saying it was only on this occasion it happened?

A. Yes sir.

Q. And it is not something you do generally; it was another case of somebody trading on friendship, another type of pressure?

A. Yes, sir.

Q. I am sure this has been very difficult for you, the last few days. I gather that you realize now why Ford Motor Company has the policy it has?

A. Yes, I do realize this.

Q. I gather you are prepared to say that it is the policy that you are going to adhere to in the future?

A. If I am still there, yes, sir.

Q. We all hope you are still going to be there. Has there been some suggestion that you wouldn't be?

A. No, none whatsoever.

Q. I would have thought not.

MR. KNIGHT [Counsel for Ford Motor Company]: I should tell the Commissioner that the suggestion has been quite to the contrary.

Chrysler Canada which, for convenience, I shall refer to as Chrysler, is a large industrial employer in the County of Essex. For present purposes, I need only describe briefly how some health information is maintained by that corporation.

Chrysler also has a medical department. There are 15 full-time nurses and seven part-time nurses employed, along with an x-ray technician and a medical secretary. The plant does not have a hospital, but rather the offices of the medical director, Dr. Schisler, operate as a central area with satellite first-aid stations throughout the various plants. Medical records are maintained at the first-aid stations and in Dr. Schisler's office. Chrysler has a workmen's compensation department and a sickness and accident claims department which are located adjacent to each other but physically separate from the medical director's office, although in the same building.

The functions of the workmen's compensation department and the sickness and accident claims department are similar to those of Ford. There is one fundamental difference between Ford and Chrysler, however, in that the sickness and accident section at Ford forwards the original applications and supporting medical reports to the sickness and accident insurer, while at Chrysler the sickness and accident claims department retains the original applications and supporting medical reports and issues the cheque as the agent for the sickness and accident insurer.

It is clear that at all times Chrysler had a general policy that no information of a health nature was to be released from an employee's record without the employee's authorization.

Cy Crossley is one of seven persons employed in the insurance claims department at Chrysler as a claims analyst. Because of the necessity of determining whether a claim was pre-existing, related to an industrial accident, or resulted from an accident and compensable under the sickness and accident policy, there was, necessarily, a free flow of information between the

workmen's compensation department, sickness and accident department and personnel department. The personnel department was the repository for the results of pre-employment physical examinations and x-rays. Mr. Crossley was named as a confidential source. He admitted that from time to time Mr. Jolie called him and that sometimes he divulged to him the period of disability and the amounts of benefits paid to an employee who had been involved in a motor vehicle collision. He said that, although he provided this kind of information, to the best of his knowledge, he never gave Mr. Jolie any health or medical information. He testified, and I accept his testimony, that he believed that Mr. Jolie was acting in the best interests of the employee and on the employee's behalf. However, he candidly admitted that if he had known Mr. Jolie was acting in an interest adverse to the employee, he probably still would have given the information.

Glen Arthur Essery is also employed at Chrysler as a claims analyst. He also was named as a confidential source by Mr. Jolie. He provided Mr. Jolie with information similar to that described by Mr. Crossley. Mr. Essery testified, and I accept his evidence, that he believed that Mr. Jolie was acting on behalf of, and in the same interests as, the employee and that had he not held this belief, he would not have provided information to Mr. Jolie.

The evidence makes it clear that there is a distinction between the case of Mr. Fedory, on the one hand, and Messrs. Crossley and Essery, on the other. Mr. Crossley and Mr. Essery were tricked into releasing information. Mr. Fedory was not.

The Windsor Separate School Board is an employer of 800 persons in the Essex County area. Information about its teachers and other employees is kept in its central administrative office. There is some health information maintained in these files, namely, physicians' certificates, filed in support of applications for either sickness and accident benefits or workmen's compensation benefits. The Board's express policy is that no health information about an employee may be released without that employee's express written authorization.

Catherine Greenwood was employed by the Board in the teachers' payroll department. Wilbert Stephens is a purchasing agent for the Board, and sometimes acts as its administrator of personnel. Mrs. Greenwood was introduced by Mr. Stephens to Mr. Todd and was instructed to provide information to Mr. Todd. In response to these instructions, Mrs. Greenwood provided Mr. Todd with such information as date of employment, address, telephone number, salary and classification. She denied,

however, and I accept her evidence, that she gave health information to Mr. Todd. In any event, Mrs. Greenwood was following express instructions and her conduct cannot be criticized.

Patricia Michaud was a clerk in the sickness and accident department and was instructed by Mr. Stephens, her superior, to co-operate with Mr. Todd and to provide:

...dates of absences and explanations as to whether it was compensable, or sick leave, and dates of return, for the past couple of years...

Mr. Stephens was acquainted with both Mr. Jolie and Mr. Todd and knew that they had been previously employed by Retail Credit Company of Canada Ltd. From time to time, Mr. Stephens provided information from the Board's records to Mr. Jolie and Mr. Todd. He said that he had no recollection of instructing his subordinates to co-operate with Mr. Jolie or Mr. Todd.

Miss Michaud is an intelligent, conscientious and careful person. As a matter of practice, she made notes for her personal benefit, particularizing information provided in every case. Her notes, pinpointing the date and substance of information given, were of considerable help to me in arriving at the conclusion that Mr. Stephens, had in fact, expressly instructed her to provide this information.

Miss Michaud testified, and her notes and the investigation reports verified, that Mr. Stephens was one of Mr. Todd's sources of information. The following is an extract from an investigation report containing information given by Mr. Stephens.

This source stated that he did not have the records on the claimant but was aware that there had been a problem with Mr. , as he has missed a considerable amount of time over the past several years, for one reason or another. He then referred us to Mrs. , the secretary, and she stated that the subject has been off numerous times for various claims. She stated that he was off from October 12, 1976 until January 10, 1977 and then went off again on January 20, 1977 and did not return to work until June 6, 1977, at which time he returned to his normal duties. He has not missed any time since then. She stated that the claimant

fell off a ladder on July 13, 1976 and injured his left knee. She stated that he did return to work on July 14, and did put in a compensation claim, # . She stated that there has been a very large file on this man and other claims are shown as May 21, 1975, dated returned not indicated, claim # . At this time it was indicated to be a recurrence of a previous problem, apparently a recurrence of aggravated previous injury to his right knee. She stated that he had filed two claims in connection with the one injury, one dated October 27, 1975 and the other dated January 22, 1976. This was all through the previous claim number # . Also another claim dated September 5, 1975 with the same claim number, another dated June 11, 1975 with a recurrence of the previous injury. He was also off May 21, 1975 and returned May 27, 1975, had hurt his arm, abrasions to his right arm and abrasion and bruises to his right knee. She stated that he had also filed a previous claim for injury to his right shoulder, dated April 29, 1969, claim # . Another injury to his right shoulder October 2, 1972, claim # , this being an injury to his right shoulder. Another claim was filed March 4, 1975, right shoulder and back, the injury having occurred on February 24, and he returned to work on March 3, 1975, claim # . Another claim dated December 2, 1974 referring to previous claim # , was off from December 2 to 5, 1974 for back problems. Another claim dated September 30 to October 4, 1974 for recurrence of back problems. Another time off September 4, 1974 to September 23, 1974 with a recurrence of a back problem. The original problem apparently occurred February 7, 1974 and he returned to work February 11, 1974 with this back problem. This source also stated that the claimant had surgery on his right knee on September 14, 1973 and this was apparently related to a previous accident December 29, 1970 when he slipped at work. The claimant also had a torn cartilage on his right knee which dates back to September

1969 for a non-compensation claim and then apparently had surgery in July 1970 for this torn cartilage. The records are not clear here however would indicate that the subject had a car accident in November 1969. He had tried to claim this right knee injury through workmen's compensation however the claim was denied. A physician stated that they were not aware of this being a compensation claim, that a car accident had been the claim. The subject was off on July 14, 1970 at which time he aggravated the previous right knee injury. The claim had been denied by the compensation board as it was felt that the original injury was the cause of the knee problem. There is another claim shown in October 3, 1972, claim # , the right shoulder and arm. He was off 3 days at this time and no date was indicated as his return to work date. Another claim dated June 7, 1972, # , for injuries when he slipped on a wet floor. It was not indicated when he returned to work. Another claim dated February 4, 1972 bruised left hand, claim # . Another claim dated April 27, 1969, fell on right shoulder, returned to work May 21, 1969, claim # . Records also show in 1974, subject had been seen by Dr. G for a brain scan. Nothing else indicated on this file regarding this incident. On July 7, 1966 he was off one day, claim # injured right frontal area, forehead 1" laceration on forehead. Apparently a venitian blind fell on his forehead. He had been under the care of Dr. P in February 1974 however there is nothing shown as to what this was related to. He was off from December 30, 1975 and returned January 19, 1976 on sick leave. He was also off again on January 22, 1976 for an operation and this was changed to a compensation claim however it was not allowed. He returned to work April 5, 1976. He went off again April 8, 1976 and returned April 20, 1976, for recurrence of a previous problem. He went off again on July 20, 1975, had to miss one hour a day right up until July 13, 1976 and then again from July 22 to August 4 was off again for an hour a

day for therapy treatment. He was off sick from September 13 to October 4, 1976 and then again as a result of this accident was off work from October 12, which is a Tuesday, the accident having occurred on the 8th, a Friday. He returned to work on January 10 then went off again January 20, 1977 returning to work on June 7, 1977 and has been working steadily ever since. Employer indicated that the subject would not be allowed back to work unless he was fully recovered and he has been carrying on his normal duties ever since.

As I have already said, the Board's policy was that no health information about an employee might be released without that employee's express authorization. Mr. Stephens testified that he did not know that was the Board's policy. I cannot accept that evidence and must conclude, therefore, that he provided information to Jolie & Todd Investigations knowing that in so doing he was acting contrary to the policy of his employer. Mr. Stephens was, therefore, truly a confidential source who gave Jolie & Todd Investigations information that ought not to have been given. I add, though it is probably unnecessary to say it, that Miss Michaud's conduct is not open to criticism of any kind.

Vernon Messer is a physician who operates the Windsor Industrial Medical Clinic. The clinic employs seven general practitioners, a surgeon, a physiotherapist, and an internist at three separate locations in the City of Windsor.

The policy of the clinic was that health information would not be released without the written authorization of the patient. The clinic has a central records department. Dr. Messer had access to all health information of each of the patients, whether or not he was the treating physician. The nature of the clinic is that a patient may attend and see any available physician.

Dr. Messer was shown extracts from two reports prepared by Mr. Jolie, which read as follows:

[A non-physician employee of the Windsor Industrial Medical Clinic] had to be interviewed on about three different occasions before we could get much information. He did state that your claimant has been with them for some 5 years and is on salary of

\$1,150.00 a month. He is a technician or medical assistant or orderly, whichever name suits the job, but mainly helps out in the treatment of people coming into the clinic. He has a good record with them and is well regarded. He is described as a slight man who has enjoyed good health in the past, but has had at least two accidents, maybe three, and has had some injury as a result of these. Records indicate that following the first accident, he was off October 28, 29, 30, and 31, then November 1, 2, 5, 6, 7, 8 and 9 and was docked pay for this time. He also missed some 3 days following the second accident. [The employee] could not confirm definitely that there was a third accident, but does know that your claimant had had quite a bit of trouble since and has had a great deal of therapy treatment, that he does not have regularly scheduled treatments, but will take a treatment whenever his condition seems to be getting worse or when there is an opening for him to go in. He receives his treatments right here at the clinic. He stated that your claimant seems to be suffering bad pain at times, that he wears a cervical collar whenever he has to and is still having trouble right up to the present time. He does not feel that your claimant was over the effects of the first accident when the second accident occurred. (This was confirmed by neighbours who indicated that he was wearing a cervical collar for quite a long time starting last year and that his appearance etc. has not changed to any degree.) [The employee] stated that your claimant does not have any actual heavy duties and that he is able to handle the work required for him which is working with patients who come in for treatment at the clinic.

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We then checked with the Windsor Industrial Medical Clinic, west end branch, and learned that they first saw this man due to an accident September 19, 1972, saw him again for another accident on March 20, 1973, this

accident occurring March 17, 1973, at the corner of University and McKay. In the first accident he was seen by Dr. C and x-rays of the cervical spine and facial bones were taken at that time. Records do not show whether he was referred to Dr. S at that time, however, following the second accident, he had x-rays of the neck and lower back and was seen by Dr. D as Dr. C was no longer with the Medical Clinic at that time. Their records indicate he was last seen March 25, 1973. He apparently has had some therapy treatment here and it is definite that Dr. S did see this man following one of these accidents, however, their records are not too accurate in this respect. It would appear that the accident on September 19, 1972, could have been the more serious....

He was unable to give an explanation for the release of this information.

A non-physician employee of the clinic provided this health information without the authorization of the employee who was also a patient of the clinic. It is therefore clear that that employee had access to confidential health information which he ought not to have had. Dr. Messer, of course, is responsible for the security of his records and the actions of his employees.

As a result of our hearings, Dr. Messer sent a directive to all of the employees of the clinic to ensure that the policy prohibiting the release of health information without authorization is strictly adhered to.

Dr. Joseph Berkeley specializes in physical medicine and rehabilitation. He employs one full-time and five part-time physiotherapists, one nurse, two full-time secretaries and one part-time secretary. Because of the nature of his practice, he is in close contact with lawyers practising in personal injury litigation and the insurance industry. He receives numerous requests in writing from lawyers and insurance companies, but the rule that is followed in his office is that no information is released without the written authorization of the patient.

Dr. Berkeley has employed Barbara Helen Coleman since June, 1972. Her function in the office was described by her in this way:

...receptionist, appointments, taking care of doctor's patients, his billings, scheduling for x-rays, tests or anything that might have to be done by a patient.

Mrs. Coleman had access to patients' charts.

She knew Mr. Jolie because she and her husband played golf with him. She was named as a confidential source by Mr. Jolie. She was, however, in a different position from that of Mrs. Todd and Mr. Fedory. I accept Mrs. Coleman's evidence that she honestly believed that if she did not give the information, Dr. Berkeley's patients would not receive their sickness and accident benefits. Mrs. Coleman was in the same position as many other physicians' employees and hospital employees in the Province who provided information under a misapprehension of fact. For this reason, there cannot be any serious criticism of her conduct.

As I have said elsewhere, 1,597 investigation reports were placed in evidence at the hearings relating to the insurance industry. These reports disclosed 18 physiotherapists throughout the Province who had been contacted by investigators in attempts to obtain health information without patient authorization. Sixteen of the physiotherapists were from elsewhere in the Province than Windsor. These 16 physiotherapists, in total, were contacted on 22 occasions.

Roy G. Wardle and Frank J. Farrell are physiotherapists who carry on the practice of their profession in the City of Windsor. Mr. Wardle disclosed confidential health information to Jolie & Todd Investigations on 28 occasions. Mr. Farrell's office disclosed confidential health information to Jolie & Todd Investigations, on nine occasions. The type of information disclosed by Mr. Wardle is illustrated by the following extracts from two separate investigation reports.

We learned from this source that Mrs. began her therapy treatments on March 8, 1973, and discontinued on July 13, 1973. She had been attending three times a week here. He stated that she was improving somewhat however, on the advice of her doctor, the therapy was stopped. He had no knowledge as to what the exact state of her condition is at the present time as she has not returned for further treatment.

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Stated that the claimant was in for therapy during the period of May 6, 1975 through June 27, 1975, for a spiral fracture of the right tibia and fibula. He indicated that he came in for a number of various types of exercises covering range of motion, whiplash, and strengthening exercises. It is understood that the injury was somewhat slow in healing, that there was non and partial healing at times and apparently quite a bit of work was necessary to bring this man back. They have had no contact since June 27, 1975, at which time it was felt that his muscles etc. had been strengthened enough that he would not need further therapy.

Mr. Farrell testified, and I accept his evidence, that information was given by his staff in the belief that the investigators inquiring were acting in the same interest as the patient. Mr. Wardle was not in Windsor at the time of our hearings. He later explained to Mr. Strosberg, an explanation I accept, that he was under a similar misapprehension.

The type of information disclosed by Mr. Farrell is illustrated by the information obtained from the report a part of which I reproduce:

This source stated that _____ had received 10 treatments starting in March of 1975. The last treatment was on April 15, 1975. She stated that they had not treated him prior to this time or since this time.... In January 7, 1976, he did undergo one treatment consisting of diatherm and massage. He was billed \$4.45 under OHIP and received no further treatments. He was referred to this physiotherapist by Dr. D with a diagnosis of whiplash. There was no diagnosis of a back problem listed...

The codes of ethics of the Chartered Society of Physiotherapy of Great Britain and the Canadian Physiotherapy Association, to both of which organizations Mr. Farrell belonged, require a physiotherapist to keep information about his patients confidential. However, The Drugless Practitioners Act, R.S.O. 1970, chapter 137, under which physiotherapists, chiropractors and others are regulated, is silent about the matter.

Recommendation:

10. *That The Drugless Practitioners Act be amended to impose an obligation of confidentiality with respect to the health information of patients.*

Because Windsor is a city of approximately 200,000 people, and because there are only two independent physiotherapists, and a handful of persons involved in physiotherapy, I have no doubt that it was a simple matter for investigators to call each of the physiotherapists to determine whether a claimant was a patient. I believe that the size of the community and the small number of physiotherapists account for the disproportionately large number of contacts. However, I think it is significant, and indicative of a lack of concern for confidentiality, that both of these physiotherapists believed, and were prepared to accept at face value, the representation that persons known to them as investigators were always acting in the same interest as their patients, especially when they knew that their patients had been involved in motor vehicle accident cases which would give rise to claims against insurance companies.

Ottawa Pharmacy Ltd. is a corporation which operates a pharmacy and employs three pharmacists in Windsor. Jack Harold Stein, a pharmacist and the principal of Ottawa Pharmacy Ltd., appeared and gave evidence at our Windsor hearings. He was named as a confidential source of Jolie & Todd Investigations. Mr. Stein, however, was not in the same position as Mr. Fedory and Mrs. Todd, because he honestly believed that Mr. Jolie was acting in the same interests as his customer. He was, therefore, in the same position as every other professional who was the victim of a pretext and who disclosed confidential health information.

Mr. Stein said that in addition to such information as address, telephone number, date of birth and the like, a pharmacist's record shows whether there is a third party insurance plan, particulars of that plan, the allergies or any idiosyncrasies of the customer, as well as particulars of each prescription filled, the date on which it was filled, the name of the drug, the quantity of the drug, general directions involved, the name of the prescribing physician, the number of refills allowed and the price. In the case of Ottawa Pharmacy Ltd., this information was kept on cards at the counter of the pharmacy section and was accessible to all members of the staff.

Mr. Stein was asked to explain what contacts he, as a pharmacist, had with hospitals. He answered that, from time to time, employees from the emergency departments of various local hospitals telephoned him, provided him with a prescription number and asked for particulars of the type of drug involved because their patient, they believed, was suffering from an overdose. There have been fewer calls since 1976 because at that time the name of the prescribed drug, in addition to a prescription number, began to be routinely affixed to the vial.

Mr. Stein pointed out that much may be learned from the type of medication prescribed for a customer. For example, it is possible to conclude, depending on the strength of an analgesic, whether a customer suffers from simple headaches, or migraines, and, similarly, the strength of a tranquillizer may be suggestive of emotional problems or simply muscle problems. Mr. Stein believed that he had no obligation to keep health information confidential. The code of ethics adopted by the Ontario College of Pharmacists, and made part of its by-laws, provides that, "A pharmacist should respect the confidential and personal nature of his professional records; except where the best interest of the patient requires, or the law demands, he should not disclose such information without proper patient authorization." The Health Disciplines Act, 1974, S.O. 1974, chapter 47, does not specifically impose an obligation of confidentiality upon pharmacists. However, O.Reg. 579/75 under this Act does include in its definition of professional misconduct, "conduct or an act relevant to the practice of a pharmacist that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional." Since a code of ethics has been adopted in which confidentiality is expected, presumably pharmacists generally would reasonably regard a breach of that Code as disgraceful and unprofessional.

I have taken pains to review Mr. Stein's evidence in detail, not, I wish to make it clear, because I consider him culpable but because he was the only pharmacist to give evidence before me and I wanted to use this evidence to demonstrate the type of records kept by, and the obligations of, pharmacists in Ontario.

To fulfil its welfare or social service responsibilities, the corporation of the City of Windsor established a Social Services Department to deal with matters relating to these payments, commonly known as welfare payments, and to maintain a file on each person who applies for social service benefits. Margaret Elizabeth Crowley is a clerk who has been employed by the Social Services Department since about 1966. Mrs. Crowley

has access to all the files in the Social Services Department. Of necessity, some of these files contain health and medical information. All the employees of the Social Services Department are bound by the obligation not "to cause to be made public, the identity of any person who is eligible for or receives assistance" as set out in Regulation 383 under The General Welfare Assistance Act, R.S.O. 1970, chapter 192.

Mrs. Crowley is a long standing acquaintance of Mr. Jolie and a friend of his family. Mrs. Crowley was named as a confidential source by Mr. Jolie. She admitted that Mr. Jolie had called her five or six times a year since 1974. She recalled giving Mr. Jolie information but denied ever providing him with health information, other than whether a recipient had been involved in an accident and had suffered injuries. The general type of information provided is similar to that contained in a report which reads, in part, as follows:

Stated that the claimant has been known to them for a number of years, until a little over two years ago when she went on a provincial pension. She has no other source of income. Their records indicate she has been at [redacted] since about 1968. Records further indicate that she had some kind of an accident on Ouellette Avenue in 1971, that there is indication that the case was investigated however the report of this investigation is gone. It would appear that there was no liability on the part of anyone else and for this reason the whole matter was dropped. No further information was available here.

Mrs. Crowley believed that Mr. Jolie was in the credit business and, although she readily acknowledged that she ought not to have provided this type of information to him, she did so in the belief that he was acting in the interest of the recipient. Her reasoning was that since he was in the credit business, if he knew the recipient was receiving social assistance, there would be less pressure on the recipient to pay outstanding debts.

The Corporation of the City of Windsor also employs a workmen's compensation officer. Gary Anthony Patterson gave evidence and described his function and duties as being similar to that of Mr. Fedory at Ford. He assists in the processing of workmen's compensation applications and has access to substantial amounts of health information relating to compensation claims. The files relating to workmen's compensation claims are

kept separate and apart from other health information from pre-employment medicals which are kept in the personnel file at a different location in the City's offices. In his work, however, he has access to these personnel files. The City of Windsor does not have a written policy relating to the release of information, but Mr. Patterson had been orally instructed not to release information without authorization. Mr. Patterson received a call from Mr. Stickley, who had been an acquaintance since school, in or about 1974, and Mr. Stickley asked him to confirm certain information. Mr. Patterson testified, and I accept his testimony, that he never provided Mr. Stickley with any medical information, but gave him only certain basic employment information which he was entitled to release.

Privacy has been defined as the right to choose to whom information about oneself should be released. When a special relationship is established and a person chooses to release confidential information about himself, to, for example, a physician, physician's employee, or hospital employee, he or she does so in the expectation that the recipient of this information will respect the confidence and refrain from releasing the information to another. The Windsor experience shows that recipients of confidential health information must be more careful and discreet in their handling of this information. It is true that it was wrong of Messrs. Jolie, Todd and Stickley to capitalize on friendships and relationships to obtain information which they traded for a profit. However, it was also wrong for custodians of health information to have become, like so many others in the Province, less than careful about their responsibilities of confidentiality to such a degree that a wholesale exchange of confidential information occurred to the extent I have described.

CHAPTER 13

State Farm Mutual Automobile Insurance Company

State Farm Mutual Automobile Insurance Company, which I shall call State Farm, is an automobile casualty insurer carrying on business in Ontario. Rather than retain independent adjusters, it prefers to use staff or in-house adjusters. In 1978, it employed approximately 50 staff adjusters to adjust claims and only on occasion retained independent adjusters.

In 1974, a State Farm staff adjuster named Smith misrepresented himself as an OHIP official to a claimant in an attempt to extract from that claimant his OHIP number. Mr. Smith wanted the number in order to contact the subrogation department of OHIP to attempt to settle its subrogated claim directly with it. Elsewhere, I deal in greater detail with the operations of OHIP's subrogation department. Brian Bechard, a divisional claims superintendent, testified on behalf of State Farm and, admitting that this incident had occurred, said that it had been indefensible and wrong and added that since that time State Farm had been monitoring Mr. Smith's activities.

On October 10, 1977, an automobile insured by State Farm struck the rear of another automobile and injured a claimant. I shall review the resulting claim in some detail because it is a case of a State Farm employee obtaining health information without a claimant's authorization. It also illustrates the motivation for resorting to this practice, and that is a belief that the claimant was dishonest, a not uncommon assumption, according to the evidence, made by investigators and adjusters engaging in the practice. As in almost all the cases we examined, the assumption was without foundation. Unfortunately, in this case the adjuster's assumption rested on the fact of the claimant's perceived nationality and the fact that he was represented by a lawyer! These facts led the adjuster to the conclusion that the claimant was insisting on a larger settlement than he was entitled to. The case underlines the specious nature of the justification for resorting to "dirty tricks" and the need for vigilance in the protection of confidential health information.

After the accident State Farm's insured automobile owner reported the collision to it and, as a result, Richard Wolynec,

a staff adjuster, was assigned to the claim. Mr. Wolynec's management of the case can best be illustrated by reference to State Farm's own memoranda in its file:

To: Harry Clancy
From: Richard Wolynec
Date: October 27, 1977
RE: Claim No. 38-2662-551
Insured:
c.c. Larry McLeod
Superintendent
750 West Sproule Road
Springfield, Pennsylvania
19064

PARTIAL CLR
7. OCCUPANTS OTHER THAN INSURED
VEHICLE PEDESTRIAN CYCLIST, ETC

A. NOT INJURED

Not applicable.

B. INJURED

The Claimant is Mr. residing at Way, Apt. , Don Mills, Ontario, telephone number . Mr. is married and employed by Company, Toronto, Ontario. Mr. is employed as a Payroll Clerk.

He is earning \$190.00 per week. I have not been able to personally interview Mr. as on two occasions, I have attended at his apartment residence and was refused entry. Mr. at the outset stated that he would be obtaining a solicitor and his attitude was one of hostility and indications of a professional claimant.

Status

Mr. was the driver of his 1970 Chev.

Injuries

Mr. received a cervical extension with accompanying upper back strain.

Disability

Mr. has been away from work since the date of the accident and has been unable to return due to his neck and back complaints. Mr. is still off from work as of the date of the dictation of this report being October 26, 1977. I feel that he will be off for an additional three to four weeks for a total of 5 to 6 weeks.

Loss of Wages

Mr. does not have any disability plan at work and this was confirmed by myself with the Personnel Manager, Mrs. . Allstate will be providing \$70.00 per week of disability payment under their policy which will leave a net wage loss of \$190.00 minus \$70.00 for a net wage loss of \$120.00 per week. I have verified with Allstate that they did in fact send out Disability Forms but our claimant has not returned them. Allstate's file number is 59-J24701-G.

Special Damages

I feel that we should set up \$150.00 for physiotherapy treatments. The employer has received information that he will be attending physiotherapy treatments as a result of his injuries. I would also suggest \$22.50 for several doctor's visitations.

Medical Authorization

Unable to obtain due to third party not responding to my attendance at his residence.

Doctor's Name and Address

The claimant is seeing a General Practitioner by the name of Peter Carr. He is duly qualified to practice in Ontario. I am not aware of his personal capabilities.

Medical Reports

No medical report has been filed with his own insurer as of the date of dictation.

Independent Examination

I feel that this claimant gives all the signs of being a professional and would recommend an independent examination at an early date. I will keep in touch with his own insurers to see if they will in fact instigate an independent medical examination, should he be off for any length of time.

Hospital

I understand that he attended a Hospital at Niagara Falls, Ontario but I am not aware of the name.

O.H.I.P.

I have put O.H.I.P. on notice via their Standard Notification Form.

Statement

Mr. [redacted] after several attempts at seeing him in person did finally re-contact me via the telephone and did give me confirmation of the facts as given in our ACR.

The facts were that our insured did rear end him.

9. ATTORNEY

I have now found out that he has retained Ed Futerma as his solicitor. I am quite aware of Mr. Ed Futerma's ability and his usual high demands. Mr. Futerma has in the past demonstrated the ability to refer his clients to several Medical Practitioners who tend to be plaintiff oriented in their prognosis. I feel that this file will be around for at least 12-18 months.

10. PROPERTY DAMAGE

Mr. _____'s 1970 Chev was put under repair under his own policy with Allstate Insurance. At the date of my assignment, the car was under repair.

16. ANALYSIS & EVALUATION

Our insured, _____ was proceeding behind the third party on Queen Victoria Parkway. The third party slowed for traffic and our insured due to her inattentiveness and failure to keep a proper distance from the third party vehicle struck the third party in the rear portion of the vehicle. I feel our insured will be found guilty as charged. I do not feel we have any defense. I feel the third party did not contribute in any form as he merely was following traffic and stopping for traffic ahead. Obviously, our insured possibly due to her unfamiliarity to the area was not fully paying attention.

Injuries: The third party received a cervical extension and upper back strain. I feel this claimant will malinger for at least six months. Mr. _____ is of East Indian descent and a recent immigrant to Canada. All indications to date are that he will build the claim up. The evidence of procuring Mr. Ed Futerman in my mind would indicate that this man has had a prior claim. I am checking with Allstate in order that I may obtain his complete prior driving experience while insured under them. I will keep in contact with the third party's employer to determine the actual date that he returned to work. I would suggest that we reserve \$1500 general plus a possible 6 weeks' wage loss at \$120.00 per week for a total wage loss of \$720.00 wage loss net after total disability I also would suggest \$150.00 for physiotherapy treatments and \$23.50 for Doctors' visitations. I will advise of the

general and special reserves as more information becomes available.

19. UNFINISHED ITEMS

Try to obtain more medical information from Third Party carrier.

RW/26-28/kd

To: Harry Clancy
From: Richard Wolyne
Date: October 19, 1977
RE: 38-2662-531

OCT 24 1977

NARRATIVE BIP REPORT

Harry, I have attended twice on this new claimant's residence and have been refused entrance to his apartment residence at Way, apt. , Don Mills. I have therefore followed up with the employer at Company, Avenue, Toronto, Ontario. I have confirmed with the employee's personnel manager that he has been off since September 30, 1977 being the last date worked. The accident occurred on October 7, 1977. The employer's manager confirms that he is a payroll clerk earning \$190.00 per week and has been off since October 8, 1977. Mr. refuses to see me, and states that he is getting a solicitor. I have discussed the benefits of dealing directly and he has suggested that he will possibly contact me on October 18, 1977 for a possible discussion with me. He does not promise that he will meet with me, but I shall await his phone call on October 18, 1977. I feel that this third party is playing games. I have attended early in the morning, Monday, October 17, 1977 at his residence with his wife stating that he was not at home at 9:00 a.m. in the morning. I followed up with his employer and he obviously was not there, and has been off since the date of the accident. The third party is seeing the doctor, Dr. C, re his injuries. The third party is of East Indian descent and I feel that nothing short of \$2000 will eventually settle this claim. My experience with these people has been

that they tend to demand a great deal of money with a final boarder situation coming down to any amount from \$1000 to \$2000. I cannot understand why he will not meet with me, as mentioned above. I have offered the various benefits of dealing directly with me, i.e. the advantage of settling at an early date, rather than settling a year to two years down the road with a solicitor. I shall await until October 18, 1977 and hopefully will be able to meet with him.

RW/Y14/g

c.c. Larry McNeill, Supt.
750 West Sproule Road
Springfield, Penn 19064
USA

Richard Wolynec
Harry Clancy
November 4, 1977

38 2662 551

Richard, this partial CLR was dictated October 27, a real improvement indeed in form, continuity and grammar.

Secure an independent medical if you wish. There will be no improvements in the claimant's condition before settlement. Secure a background only, check from Equifax files. Could give you some leads.

Did you confirm the facts through the insured?

That's the drawback in a partial CLR. You might have some degree of negligence on the part of the third party. Anything that could provide us with cause to initiate an action would suffice to force the claimant solicitor to play his cards prematurely. Was our insured or any of his passengers injured?

What about repairs to the insured vehicle.

HC/B24/kd

TO: Harry Clancy NOV 21, 1977
FROM: Richard Wolynec
DATE: November 17, 1977 RE: 382-662-551

Harry, I acknowledge your memo of November 4, 1977.

The U.S. Office agrees that the accident is quite clear and in the event that I require an insured's statement, they will be only too glad to send one. Obviously, the insured would have instructed his agent differently had the situation been anything more than a straight rear ender. Liability, in my opinion, therefore, is solely upon our insured.

I have written Ed Futterman, the solicitor representing the claimant, . I have indicated in my letter to him that, in my opinion, the claim is very minor as the claimant wanted to settle with me directly, but the matter simply boiled down to quantum. The claimant, at the outset, would have settled for \$2,500, but obviously, taking into account that date of the accident, this was not feasible. The claimant then followed up the next day with the solicitor's name. In my opinion, this claimant is strictly a malingeringer and suffering from compensation neurosis. I feel that his own insurers, Allstate, would be wise to have this man for an independent medical examination should the claim last any longer than 3 months. I will be glad to remind them of my contact and handling with their insured and his intentions.

I will keep you advised as to the possibility of an independent examination being set up by Allstate.

RW/B20/1j

To: Harry Clancy DEC 14, 1977
FROM: Richard Wolynec
DATE: December 12, 1977 RE: 38 2662 531

Harry, I have verified with the third party insurers, Allstate Insurance, that the third party, , returned to work November 20, 1977. The total time off was five weeks six days for a total disability payment under his own policy of \$410.

The diagnosis by the doctor was soft cervical extension, headaches and upper back spasms. The solicitor on this file is Mr. Ed Futterman. I have dealt with this solicitor in the past. I feel that it will take at least six months prior to the solicitor setting the file down for possible discussions. I will keep after him and try to bring this to an early resolution.

RW/021/1j

TO: Harry Clancy JAN 16, 1978
FROM: Richard Wolynec
DATE: January 13, 1978 RE: 38-2662-531

Harry, I have been in touch with solicitor
Futerman regarding claimant . The
solicitor is not at present ready to sit
down to discuss this matter. Mr. Futerman
did indicate that his client was off five
weeks and once he is in receipt of all his
specials and medicals he will sit down with
me. I feel that we should diary this for at
least 60 days. We do know the claimant is
back to work and functioning properly.

RW/B33/bs

TO: Harry Clancy FEB 21, 1978
FROM: Richard Wolynec
DATE: February 17, 1978 RE: 38 2662 531

Harry, I have tendered an offer to solicitor
Futerman re his client . The offer
tendered was for \$1,200.00 generals plus
proven specials. The specials as known to
myself are 41 days loss of wages at \$190.00
per week less the TD benefits leaving
\$120.00 a week for five weeks and six days.

I feel this is the only way to have Mr. Futerman move. My experience with him in the past has been very frustrating. Mr. Futerman takes anywhere from 12 to 24 months to finally get his medicals together and sit down and discuss the claim. I will reply to you once I have a response to my offer.

RW/08/bs

TO: Harry Clancy MAR 9, 1978
FROM: Richard Wolynec
DATE: March 7, 1978 RE: 38-2662-531

Harry, I have followed up with solicitor Ed
Futerman re settlement discussions.

Mr. Futerman indicated that he does not discuss any claim prior to at least six months transpiring. The offer made by myself to him in the amount of \$1,200.00 general has been turned down by his client. Mr. Futerman is still awaiting medical reports. The client is back to work with no problems and this is confirmed by the employer.

It is simply a case of the solicitor obtaining all the medicals and sitting down with myself.

rw/vp/r26

MEMO-GRAM

FROM: Harry Clancy TO: R.G. Wolynec
DATE: 3-14-78 SUBJECT: 32-2662-551
Message:

Miss confirmed that Mr. has not missed any subsequent time other than was initially reported. Mr. is not having any problems in fulfilling his duties as payroll clerk. I attended at his Parlim. office but the doctor was at his Kipling office. I will report later.

Richard Wolynec
Harry Clancy
March 10, 1978

38-2662-551

Received yours March 7, 1978.

I suggest contact with the employer and the doctor in person to obtain a current status with respect to this claimant. I do not recommend further contact with Mr. Futerman for obvious reasons.

hc/vp/b25

MEMO-GRAM

DATE: 4/20/78
FROM: H. Clancy TO: R. Wolynec
SUBJECT: 38-2662-531
Message:

I had a chance to speak to Doctor C today. He has not treated _____ for his MVA injuries for several months. He is seeing him on a weekly basis for allergy shots. I will monitor the O.H.I.P. account very closely to make sure that we are not paying for these allergy treatments. Ed Futerman is not in a position to discuss this claim.

Upon learning what was in the "memo-gram", dated April 20, 1978, Mr. Clancy wrote a letter to Mr. Futerman on May 19, from which I quote the following passages:

I understand that our Mr. Wolynec has been in communication with you to advise that we are the insurers of _____, who on the date of October 10, 1977, was involved in an automobile accident with your client which resulted in minor injuries sustained.

We have been in communication with Dr. C, who we believe to have been treating your client as a result of these injuries and it would seem that he has not been so doing for the past several months but instead, has been seeing _____ on a weekly basis for the purpose of some sort of allergy in which your client is receiving the appropriate medication.

We trust under the circumstances that you will have little difficulty in obtaining whatever supporting medical evidence you require from Dr. C, so that you might communicate with the writer and discuss settlement of this matter.

Mr. Futerman was naturally upset when he received the letter. He had a meeting in his office with another State Farm adjuster, Ric Fleury, to discuss settlement of the claim. Mr. Fleury's account of this meeting is contained in a memorandum to Mr. Clancy, dated June 19, 1978, in this language:

TO: Harry Clancy
FROM: Ric Fleury
DATE: June 19, 1978 RE: 38-2662-531

Harry, following your handwritten memo advising of the appointment with Mr. Futerman, I attended upon the third party solicitor's office on June 15th to discuss the claim. The appointment on June 14th was cancelled due to the solicitor's court involvement.

Mr. Futerman was quite friendly in his approach to me, up until the time he reviewed your letter of May 19, 1978. The solicitor stated that he had not read this letter prior to this meeting and after reading the letter he went into a small rage that contact had been made with the doctor. The solicitor at this point, immediately dictated a letter to Dr. C requesting why information was given and asking for a copy of the authorization form that was used to obtain this information. We, of course, did not have the authorization with the solicitor being involved so early in the file.

The solicitor stated that the appointment was arranged because Dr. C had finally sent in the medical report, which is attached, dated May 1st, 1978. He was even more upset in that the information in Dr. C's report of May 1st coincided with that in our letter of May 19th and stated he was not attempting to hide anything, as can be seen by the report.

The solicitor continued by stating that this is what the recent Royal Commission regarding OHIP was all about. He stated that we had no right to contact the doctor and he was even more shocked that we had even admitted that contact had been made with the doctor. The solicitor stated that should Dr. C indicate that there is no authorization, it is his intention to present this claim to the Royal Commission pointing out our wrongdoing.

In short, Mr. Futerma continued indicating that this matter was not going to sit with nothing done about it. He also stated disgust over the fact that his name was not even spelled properly and mumbling something about proper courtesy in direction of a letter of a business nature.

Mr. Futerma's attitude by this time was one of hostility and he then brought up the subject of interest on the claim. It was then explained to the solicitor that we did not pay interest unless a judgment was secured and that should this be part of his claim, that negotiations would not be able to continue. The solicitor at this point closed his book and said that was fine. He stated we knew him well enough that we should be aware that it does not matter to him whether this matter is settled now or following discoveries or following trial. He invited the file to be referred to our counsel at this point.

At this point in time, we had not even gone into his legal brief which is attached. I stated to the solicitor that it was my responsibility to try and resolve this matter, if at all possible, and asked if negotiations could continue.

You will note that the claimant was away from work for a period of five weeks at a salary of \$190.00 per week, less disability benefits for a lost wage claim for the five week period of \$600.00. The only other special damage was the OHIP account in the

amount of \$143.97, less disbursements totalling \$46.00; being broken down as a report from Dr. C (\$40.00) and (\$6.00) for a hospital report.

Mr. Futerma at this point explained that although the medical reports do not reflect it, his notes show that his client is continuing to complain of occasional pain notwithstanding the fact that this is not borne out by the medical report.

The solicitor continued by pointing out that is why the offer of \$1200 general damages had been previously rejected, due to the continuing complaints and that he felt if this matter was going to be resolved, he felt the claim would be in the \$1750 to \$2000 general damage range.

With the solicitor being in the angry state that he was, I felt it best to get rid of this exposure if at all possible. Possibly Mr. Futerma will forget about other matters should we have the claim settled. An offer of \$1500 general damages was made, plus the above specials and disbursements, plus costs of \$335.00. The total claim was \$2624.97, including costs. Although this is \$124.00 above my authority I thought it best to see if this matter could not be nipped in the bud, and considering the total amount of generals and specials within my authority, I felt it reasonable to offer this money now with the hopes this whole thing can be cleared away.

Hopefully, in my follow up with the solicitor, I will be able to calm him down somewhat as he is in a very strong position, as there is no doubt that contact should not have been made with the doctor represented by a solicitor without proper authorization.

RF/021-22/el

Encl.

I digress now to say that, although these documents were submitted as exhibits at the hearing, Mr. Strosberg did not read them into evidence or even touch upon them in his examination of Mr. Bechard. Counsel for Mr. Bechard and State Farm, however, conducted his examination of Mr. Bechard in a way that seemed objectively to attempt to justify Mr. Wolyne's conduct. As a result, in his re-examination of Mr. Bechard, Mr. Strosberg, rightly, in my opinion, felt it necessary to deal with Mr. Wolyne's assumptions and attitude as disclosed by the documents submitted in evidence. In the course of this re-examination, Mr. Bechard, to his credit, admitted that there was no justification for the manner in which this claim had been managed. I set out the re-examination in full.

Q. I didn't want to get into this, Mister Bechard, but I gathered from the substance of your replies to your counsel's questions that your view was that State Farm was acting straightforward in the best of intentions with Mister Futerma in this matter?

A. I wouldn't want to say that about State Farm.

Q. Are you saying that they were not acting in the best...

A. Our man did not, no, in contacting the doctor.

Q. No, but I am talking about before he contacted the doctor. Your counsel was suggesting that he contacted the doctor only for the purposes of expediting information and not for the purposes of extracting information, and that really this was in some way an aid in speeding up the claims process and that suggests that what was being done was being done honorably, straight, in a straightforward fashion, that the approach to the claim was being taken in a reasonable fashion?

A. I think I, the way I understood the question and answered it is that in some cases if counsel is unable to get medical information from the doctor, we will offer assistance. Maybe we have more time than he has.

Q. Are you suggesting in this specific case that there had been an offer made?

A. No, I'm not.

Q. There is no suggestion in this case that there was any suggestion by a claimant that the doctor hadn't filed the medical report?

A. No.

Q. There is no suggestion of that. In fact, I am suggesting to you that the claimant, you have read this file?

A. Yes.

Q. I am suggesting to you that the whole approach taken by your man in this file is a most unreasonable approach. Throughout the file from beginning to end?

A. Yes.

Q. Yes, he talks about in the first report that he forwarded to his, to Mister Clancy, it's the first report in the file. It's not dated. He talks about the person having a cervical extension and upper back strain and he feels that the man will malinger for six months, that he is of East Indian descent and a recent immigrant and that he will build up the claim and that because he retained a solicitor that it would indicate that he must have had a previous claim? That's what it all says, does it not?

A. Yes.

Q. In fact, it goes on to say that, it repeats that on several occasions throughout the file and on one part of the file he says that, "the claimant at the outset would have settled for twenty-five hundred dollars, but obviously taking into account the date of the accident, this was not feasible. The claimant then followed up the next day with the solicitor's name. In my opinion, this

claimant is strictly a malingerer and suffering from compensation neurosis."

A. Yes.

Q. That was his opinion on November 21, 1977, and the claim was settled for twenty-five hundred and eighty-nine dollars and ninety-seven cents? That was what the claim was settled for?

A. Twenty-six.

Q. I'm sorry. Twenty-six hundred and twenty-four dollars.

A. Twenty-six hundred and twenty-four dollars and ninety-seven cents.

Q. And ninety-seven cents. The man was prepared, the malingerer who had compensation neurosis and who was trying to extract every dime he could was prepared to take twenty-five hundred dollars?

A. Yes.

Q. It shows a total disregard of anything that was reasonable in the handling of this claim, would you not agree?

A. I agree.

Q. I am suggesting to you that the approach and the final report, June 19, 1978, cannot be defended in any way, shape or form?

A. No.

Q. The whole approach from start to finish in this file?

A. Yes.

Q. You would agree with that?

A. Yes.

I add that, from the evidence, one can only conclude that Mr. Futerman's conduct of this case was perfectly proper and that there was not the slightest justification for State Farm's position. Mr. Wolynec sought confidential information from a physician without the latter's patient's authorization knowing that he ought not to do so but persuaded that, because the claimant was of East Indian descent and because he had retained a lawyer, he was dishonest and that therefore he, Mr. Wolynec, was entitled to act in the manner I have described.

This attempt to obtain confidential information was consistent with State Farm's policy in cases in which claimants were unwilling to execute a written authorization for the release of health information. In these cases State Farm's adjusters wrote letters to the claimants' treating physicians in this form:

Dear Dr.

Re: Our Claim No:
Our Insured:

We understand that you treated _____ who was involved in an automobile accident on .

In order to expedite your patient's claim, it is necessary that we obtain a medical report from you. For your convenience, we attach a Physician's and Surgeon's Report, which we would ask you to complete.

In the event your patient has not made a complete recovery yet, we would ask that you send us this P & S Report as an interim report.

Should there be a fee for this report, kindly enclose your account when forwarding.

Attached is a self-addressed envelope for your convenience.

Yours very truly,

Claim Representative

That form letter was skillfully drafted to convey the impression to the physician to whom it was addressed that it would be in his or her patient's best interests to have the medical report

completed. Absent was any disclosure that the writer was acting in an interest adverse to that of the patient. The words "expedite your patient's claim" are similar to the pretexts used by these private investigators who introduced themselves by saying "We are processing a claim". The form letter purported to come from a "claim representative" and suggested that State Farm was in a neutral position or even in the same interest as the patient. In any event, one week before Mr. Bechard's appearance at our hearing, State Farm changed the language of the form letter so that is read this way:

Dear

Re: Our Claim No:
Our Insured:

We understand that you treated _____ who was involved in an automobile accident on .

In order to expedite your patient's claim, it is necessary that we obtain a medical report from you. If you have authorization would you please complete the attached Physician and Surgeon's Report.

In the event your patient has not made a complete recovery yet, we would ask that you send us this P & S Report as an interim report.

Should there be a fee for this report, kindly enclose your account when forwarding. Attached is a self-addressed envelope for your convenience.

Yours very truly,

In my opinion this form letter begs the question. As I shall have occasion to say later, in these circumstances, the insurance company ought not to communicate with the claimant's physician.

At the hearing, Mr. Bechard made an acknowledgment in what I have been calling the usual form and said that his company had, during 1977, on 13 other occasions, sought and received health information from physicians and hospital employees without patient authorization although its employees knew or ought to have known about the principle of confidentiality.

These 13 occasions were in addition to those on which physicians had replied to the form letter I have reproduced. I felt that it was unnecessary to put State Farm to the expense of reviewing all of its files to determine the precise number of cases in which it had received information from physicians in reply to the form letter. The fact that they had indeed received replies, and not the very number, was what was significant.

The Automobile Casualty and Liability Insurance Industry in Retrospect

On my appointment in December, 1977, I believed that this inquiry would be quickly completed and would be more theoretical than investigative. In short order, my expectations were altered. Our investigation brought to light the practice of automobile casualty and liability insurance companies as principals of investigators and adjusters participating in the obtaining of confidential health information, without patient authorization, from every conceivable source. For convenience, I shall refer to these insurance companies as liability insurance companies and to this part of this insurance industry as the liability insurance industry.

The early evidence led me to suspect that the practices which are described above were widespread throughout the industry. On more than one occasion I publicly stated that, as a matter of fairness to those individuals and corporations whose activities were initially scrutinized at our hearings with the attendant publicity, and as a matter of proper fulfillment of my duties as Commissioner, I would not discontinue my inquiry into the activities of the liability insurance industry until I examined every insurance company, investigation company, adjusting company and their employees who had been involved in the obtaining of confidential health information without patient authorization.

Repeatedly, and in public, I requested all insurance companies carrying on business in Ontario who had engaged in these activities and the liability insurance industry collectively to come forward voluntarily and disclose the scope of these practices so that I might have a sound basis for realistic recommendations. The industry eventually did come forward but only after extensive evidence of the kind discussed in the preceding pages.

The Insurance Bureau of Canada, commonly known as the I.B.C., is the major organization of automobile, casualty and property insurance companies transacting business in the Canadian market. Over 100 company groups are represented through I.B.C. and collectively these companies wrote premiums in Canada in excess of \$4 billion in 1977. This premium dollar

figure represents 95 per cent of the total general insurance premiums written by private insurance companies in Canada in the year 1977.

At one of our hearings, the I.B.C., through its counsel, R.F. Wilson, Q.C., made the following acknowledgment on behalf of its member companies:

1. The insurance industry acknowledges that hospitals, hospital employees, doctors and doctors' employees have an obligation to keep the contents of health records of patients confidential.
2. Generally members have in the past gathered through various sources medical information without authorization of the patient.
3. To determine the extent of the practice within the industry of obtaining medical information, the Bureau offered to assist the Commission by conducting a survey of its members, which survey reveals the following:
 - (a) The total number of bodily injury claims in Ontario handled in 1977 was 115,019.
 - (b) The number of cases in which investigation reports were requested was 6,240.
 - (c) The best estimate of the number of investigation reports or internal memoranda prepared by company employees, containing medical information obtained from hospitals and/or doctors' offices without the patient's consent was 420, representing 0.36 of 1% of total claims.
4. The obtaining of such information has nothing to do with the maintenance of the financial stability of the companies involved.

5. Such information was obtained to aid in the detection of and to prevent greatly exaggerated and fraudulent claims and for the establishment of adequate claims reserves. Such claims are clearly against the public interest and, if paid, would increase the cost of insurance in Ontario to Ontario consumers.
6. The Bureau is not trying to justify actions contrary to the current state of the law but would point out that such practices have not in any way prejudiced honest claimants in the settlement of their claims.
7. Knowledge of the practice has only now come to the attention of the Board of Directors of the Bureau. As a result of the information, the Bureau proposes to incorporate into an existing and operative inter-company agreement respecting standardization of claim forms and practices and guidelines for the settlement of claims, which is signed by individual companies, the provision that as a matter of corporate policy the subscribing company will not gather medical information from doctors or their employees, or hospitals or their employees, without the written consent of the patient, subject only to any right to such information under law or rules of practice.
8. The Bureau draws to your attention that in the Provinces of British Columbia, Saskatchewan, Manitoba and Quebec, where Crown Corporations participate in the general insurance business, the governing legislation requires doctors and hospitals on demand and without the patient's consent to report medical information to the Crown corporations.
9. The Bureau in a later submission will elaborate on the various points referred to in this statement for consideration by the Commission in connection with its

recommendations for legislative change
as a result of its investigations and
hearings.

The members of the I.B.C., as of the date of this acknowledgement on October 12, 1978, were the following companies:

Member Companies and Groups Insurance Bureau of Canada

Allianz Insurance Company

Abstainers' Insurance Company

Aetna Casualty & Surety Company

 Aetna Casualty Company of Canada

American Bankers Insurance Company of Florida

American Mutual Liability Insurance Company

American Reinsurance Company

Anglo-Canada General Insurance Company

 Gibraltar General Insurance Company

Argonaut Insurance Company

Atlantic Insurance Company Limited

Aviation and General Insurance Company Limited

Cabot Insurance Company Limited

Canada West Insurance Company

Canadian General Group

 Canadian General Insurance Company

 Toronto General Insurance Company

 Traders General Insurance Company

Canadian Home Group

 Adriatic Insurance Company

 Canadian Home Assurance Company

Canadian Indemnity Company

(Les Prévoyants du Canada)

The Canadian Provident General Insurance

 The Personal Insurance Company of Canada

Canadian Reinsurance Company

The Canadian Surety Company

 Edmonton Canadian Insurance Company

 Olympic Insurance Company

 Transamerica Insurance Company

Canadian Universal Insurance Company Limited

Chateau Insurance Company

The Citadel General Assurance Company

(Commerce Group)

Le Groupe Commerce Compagnie d'assurances

Commercial Union Assurance Company of Canada

Canada Accident & Fire Assurance Company
Stanstead & Sherbrooke Insurance Company
The Continental Insurance Company
The Dominion Insurance Corporation
Niagara Fire Insurance Company
Royal General Insurance Company of Canada
The Tokio Marine & Fire Insurance Company Limited
The Co-operators Group
Co-operative Fire & Casualty Company (CIS, Regina)
Co-operators Insurance Association (CIAG, Guelph)

(Independent Ins. Managers Ltd.)
Cornhill Insurance Company Limited
The Canadian Commerce Insurance Company
The Canadian Provincial Insurance Company
Provincial Insurance Company Limited
The Unity Fire & General Insurance Company
Cumis Insurance Society, Incorporated

Dominion of Canada Group
Casualty Company of Canada
Dominion of Canada General Insurance Company

Eaton/Bay Insurance Company
Economical Mutual Insurance Company
Missiquoi & Rouville Insurance Company
Perth Insurance Company

(Employers of Wausau)
Employers Mutual Liability Ins. Co. of Wisconsin
Employers Reinsurance Corporation
English and American Insurance Company Limited
Equitable Group
Equitable General Insurance Company
Industrial General Insurance Company

(Chubb & Son Inc.)
Federal Insurance Company
South British Insurance Company
Federated Mutual Insurance Company
Federation Insurance Company of Canada
Helvetia Swiss Fire Insurance Company Limited
Switzerland General Insurance Company Limited
(Shaw & Begg Limited)
Fireman's Fund Insurance Company of Canada
Foremost Insurance Company
Foresters Indemnity Company

The General Accident Assurance Company of Canada
Canadian Pioneer Insurance Company
Scottish Canadian Assurance Corporation
General Reinsurance Corporation
General Security Insurance Company of Canada
La Société d'Assurance des Caisse Populaires
Gerling Global General Insurance Company
Gerling Global Reinsurance Company
Gore Mutual Insurance Company
Grain Insurance & Guarantee Company
Great American Group
 American National Fire Insurance Company
 Great American Insurance Company
The Great Lakes Reinsurance Company
Guarantee Company of North America
Guardian Insurance Company of Canada

The Halifax Insurance Company
Hartford Fire Insurance Company
 (Monitor Ins. Group)
 London Canada Insurance Company
 The Great Eastern Insurance Company
 The London & Edinburgh General Insurance Company
The Highlands Insurance Company

The Home Insurance Company
 Seaboard Surety Company

Insurance Company of North America
Pacific Employers Insurance Company
The Insurance Corporation of Ireland Limited
Insurance Exchange Limited
 Insurance Corporation of Newfoundland Limited
 Community Life & General Insurance Company Limited
 Beothic General Insurance Co. Ltd.

Kanata Reinsurance Company

La Capitale, Compagnie d'Assurance Generale
La Companie d'Assurance Belair
La St-Maurice, Co. D'Assurances
Les Cooperants, Compagnie d'Assurances Generales
Liberty Mutual Insurance Company
 Liberty Mutual Fire Insurance Company
Lloyd's Non-Marine Underwriters
(Kemper)
 Lumbermens' Mutual Casualty Company

Mercantile and General Reinsurance Company of Canada Ltd.
Metro General Insurance Corporation Limited
Midland Insurance Company
Motors Insurance Corporation
Munich Reinsurance Company of Canada

National Reinsurance Company of Canada
Norman Insurance Company Limited
Norwich Winterthur Reinsurance Company
Nova Scotia General Insurance Company

Ontario Mutual General Insurance Company
Orion Insurance Company Limited

Phoenix Assurance Company of Canada
The Century Insurance Company of Canada
Phoenix Assurance Company Limited
Pilot Insurance Company
Pool Insurance Company

(Laurentian)
Provident Assurance Company
The Laurentian General Insurance Company
La Paix General Insurance Company of Canada

Prudential Assurance Company Limited
(PRU-RE)
Prudential Reinsurance Company of America

Reliance Insurance Company
Royal Insurance Company of Canada
British America Assurance Company
The Globe Indemnity Company of Canada
The Hudson Bay Insurance Company
The Imperial Guarantee & Accident Insurance Company of Canada
Law Union & Rock Insurance Company Limited
The Liverpool & London & Globe Insurance Co. Ltd.
The London & Lancashire Insurance Company Limited
Cie d'Assurance du Quebec
The Western Assurance Company
SAFECO Insurance Company of America
First National Insurance Company of America
General Insurance Company of America
St. Paul Fire & Marine Insurance Company
Security Mutual Casualty Company
Skandia Insurance Company
Société Anonyme Francaise de Reassurances
Société Nationale d'Assurances

Sovereign General Insurance Company
State Farm Insurance Companies
 State Farm Fire & Casualty Insurance Company
 State Farm Mutual Automobile Insurance Co.
Strathcona General Insurance Company
Sun Alliance Insurance Company
 The London Assurance
Travelers Indemnity Company of Canada
 Travelers Indemnity Company
Unifund Limited
L'Union Canadienne, Compagnie d'Assurances
United Canada Insurance Company
The United Provinces Insurance Company
United States Fidelity & Guaranty Company
 Fidelity Insurance Company of Canada

(Crum & Forster of Canada)
 United States Fire Insurance Company
 Herald Insurance Company

Universal Reinsurance Group
 Abeille-Paix Reassurances
 Netherlands Reinsurance Group (N.V.)
 The Nordisk Reinsurance Company Limited
 Storebrand International Reinsurance Co. Ltd.
 Union Reinsurance Company
 The Victory Insurance Company Limited

Utica Mutual Insurance Company

Waterloo Mutual Insurance Company
Wawanese Mutual Insurance Company
Western Union Insurance Company

York Fire and Casualty Insurance Company

Zurich Insurance Company
 Alpina Insurance Company

The I.B.C.'s members estimated that confidential health information had been obtained on 420 occasions in 1977 from hospital employees and physicians and their employees. Because of the statistical information that emerged from the evidence heard during the inquiry I believe the estimate is conservative. We dealt with 1,597 investigation files prepared by 32 separate investigation companies. These investigation companies represented 68 insurance companies and 41 independent adjusting companies. The investigation reports disclosed that 159 separate hospitals had been contacted. The contacts at the

hospitals were with various departments, for example, the admitting, the emergency and the x-ray departments. For the purpose of our statistics, every attempt to obtain information from a separate department in a hospital was considered a separate contact. There were a total of 1,252 separate contacts at hospitals and confidential health information was obtained on 940 occasions for a success rate of 75.1 per cent. There were 1,867 separate contacts with physicians or their employees and confidential health information was obtained on 1,461 occasions for approximately a 78 per cent success rate. The acknowledgment of the I.B.C. coupled with this statistical information leads me to conclude that obtaining confidential health information without patient authorization was carried out and accepted as a common and ordinary practice by the liability insurance industry including its adjuncts, the adjusting and investigation businesses.

The acknowledgment stated that the information was "obtained to aid in...the establishment of adequate claims reserves." Throughout the inquiry I asked senior officials from various liability insurance companies who appeared at our hearings whether it was necessary to have confidential health information obtained without authorization to be able to discharge the function of setting claims reserves. Almost all answered in the negative. The best expression of this opinion was given by Douglas Charles Grigg, the senior claims examiner for The Citadel, previously known as CNA. His testimony was of such significance that I set it out:

MR. STROSBERG: We discussed the question of setting of reserves. I understand that you have been in the insurance business for many years?

A. Roughly thirty, yes.

Q. You have been intimately involved in the matter of setting of reserves?

A. That's right.

Q. Do you believe it necessary for you to properly set a reserve to obtain confidential medical information without the consent of the patient?

A. No. It's not required.

Q. How do you go about setting the reserve without this confidential medical information?

A. Well basically on the physical evidence, that is the structural damage to the vehicle concerned. The length of the time of the file. As each year progresses and someone is not settled or become physically back to normal, that tells me a story it's going to cost a few thousand dollars.

Q. Do I understand that you get information from time to time from your solicitors who may be involved in a file?

A. That's correct. He receives information which he passes to me from the solicitor for the plaintiff.

Q. Do you use that information to help you review your reserves?

A. That's correct.

Q. Do I understand from what you have been saying that the process of reviewing reserves is a matter that proceeds on an ongoing basis?

A. That's right.

Q. That every piece of information you get, you put together and you attempt to determine what is fair value for the claim?

A. That's correct.

Q. So that from your experience it is unnecessary to have confidential medical information to, which is obtained without authorization, to set a proper reserve?

A. That's correct.

MR. STROSBERG: Thank you very much, sir. I appreciate your coming. I appreciate your explanation dealing with the matter of reserves.

MR. COMMISSIONER: Mister Grigg, just a question or two about the setting of reserves. How soon after you are notified of an accident which might give rise to a claim are you concerned about the fixing or setting of a reserve?

A. It's immediate upon your preliminary notice of a claim.

MR. COMMISSIONER: Well then, let's take the first opportunity you have to do this. At that stage in most cases you would not have information from the claimant's lawyer?

A. That's correct.

MR. COMMISSIONER: You would know that the claim is recent? You would have some understanding of the damage to the vehicle, and that's about all?

A. I might point out, sir, that generally the adjuster sends us a preliminary notice and he tells us, gives a description of the damage to the third party car, to our own car and bodily injuries, such as, if he tells me that the third party has been taken to the hospital, I automatically say to myself that's going to be a certain reserve.

.

A. Then when the next detailed report, I'll adjust in that reserve.

.

MR. STROSBERG: Is it not also the case that police reports indicate or contain some information which indicates the type of injury that the persons have, whether they have been taken to the hospital?

A. To the best of my recollection they merely say a person has gone to hospital by ambulance or by police vehicle or somebody else has taken them or else they don't mention it.

MR. COMMISSIONER: ...Isn't there a place on the standard report that says personal injuries or fatality or something of that sort?

A. Oh, yes, in a fatality, sir. Yes.

MR. COMMISSIONER: Isn't there one that says personal...

A. Yes, there is on the reverse side but it's only a signal, so to speak.

MR. STROSBERG: All right, we were talking about the fact that you find out that the person has gone to a hospital is something that you can get from the police report?

A. Oh, that's correct, yes.

I do not accept as valid the suggestion that the setting of reserves necessitated the obtaining of confidential health information without authorization or that the establishment of reserves could not be carried out without this information. Similarly, I do not accept as a justification that the practice was engaged in "to aid in the detection of and to prevent greatly exaggerated and fraudulent claims." Even if the claim were true it would not be a justification. But the claim is demonstrably not true. Of the 1,597 investigation files we dealt with, only a very small number, by any measure, related to greatly exaggerated and fraudulent claims. In almost all instances, the claimant was honest and straightforward. The rooting out of exaggerated and fraudulent claims was rarely the motive for referring the matter to an investigator. In most cases the investigators were retained to obtain confidential health information without any cogent reason. My impression is that such retainers were usually given without rhyme or reason, almost as if it were a necessary ritual. Often the solicitors for claimants had actually provided substantial health information to the insurer; nevertheless, investigators were still instructed to obtain confidential health information without authorization.

The question is why a reputable industry engaged in this indefensible practice. I believe that many claims persons did not direct their minds to the propriety of their instructions and the actions of their investigators. They ought to have done so and ought to have known that their actions were improper and, in some cases, illegal. Some probably simply did not address

the problem at all. Those who did, and knew it to be wrong, did not exhibit the strength of character necessary to desist, and to cause their companies to do so. The fact that so many reputable lawyers also engaged in this indefensible practice is evidence that blind acceptance of the practice was the rule, not the exception. Part of this acceptance is based on the competitive nature of the industry. Those who knew the practice to be wrong were afraid that their competitors would have a competitive advantage over them.

The evidence supports the implication made by some of the witnesses who appeared at the hearings that their ignorance of the existence of the various obligations of confidentiality was justifiable in the light of the location of the obligations, not in statutes, but in regulations. Something as important as privacy and the confidentiality of health information ought, indeed, to be set forth in Acts of the Legislature as opposed to subordinate legislation.

Recommendation:

11. *That wherever a duty of confidentiality with respect to health information is found in a regulation, it be transferred therefrom to the parent statute.*

Throughout the inquiry I expressed the opinion that all persons and bodies concerned should look to the future and that the evidence which had been given ought to be used to formulate policies to ensure that breaches of confidentiality no longer take place. In that context, a most important development was the expressed intention, later translated into fact, on the part of liability insurance companies, to agree with each other that individual corporations would not gather confidential health information from physicians, their employees, or hospital employees without the written consent of patients. The industry-wide acknowledgment and undertaking led me to conclude that it was unnecessary to proceed further with investigative hearings into more liability insurance companies and investigation companies despite the fact that there were many other liability insurance companies and other members of the I.B.C. whose conduct had not been individually examined.

Recommendation:

12. *That in connection with third party liability claims, insurance companies, their agents and representatives be prohibited from communicating with*

physicians, hospitals or other persons under a duty to keep health information confidential unless the patients concerned have expressly authorized the communication.

During the inquiry it was brought to my attention that the first-party insurers were approached for health information by investigators with a success rate of almost 100 per cent. The I.B.C., in response to a question posed by me, said that:

The practice of insurance companies providing health information to investigators from claims files, including files maintained to administer Schedule "E" benefits, has now ceased.

It is perhaps unnecessary to state, but the I.B.C.'s co-operation and statement did not come about without hard work. I am grateful for the efforts of R. F. Wilson, Q.C., Alex Kennedy, assistant general counsel to the I.B.C., A. A. Horsford, president of the I.B.C., and Roger Radford, a vice president of Royal Insurance Company of Canada, all of whom met with Mr. Strosberg and Mr. Steven Sharpe to work out the mechanics of the attendance at our hearings and the statement. I express my gratitude to these persons. Their co-operation and their commendable enterprise in having companies with such diverse interests join together to provide me with necessary information are deserving of recognition.

Although, as I have said, the attendance and statement by the I.B.C. eliminated the necessity of engaging in a clause-by-clause analysis of investigation reports prepared for many liability insurance companies and adjusting companies, the reports were nevertheless filed as exhibits at our hearings. Many individual companies filed written acknowledgment in, or substantially in, the following form:

The _____ Insurance Company ("the Company") on behalf of its officers and employees acknowledges that:

1. hospitals, hospital employees, doctors and doctor's employees have an obligation to keep the contents of health records of patients confidential;
2. servants and agents of the Company have, in the past, gathered through various

sources medical information without the authorization of the patient;

3. the Company is not seeking to justify this practice on the current state of the law;
4. the Company has reviewed its files and forwarded to the Insurance Bureau of Canada statistical information outlining the extent to which the Company has, in the past, gathered medical information from the hospitals and/or doctor's offices;
5. the Company subscribes to the statement to be made by the Insurance Bureau of Canada to the Royal Commission of Inquiry Into the Confidentiality of Health Records in Ontario;
6. the Company accepts as a matter of corporate policy that confidential medical information ought not to be sought or received without the patient's consent from hospital employees, doctors and doctor's employees by Adjusters, servants, employees, agents and investigators subject only to any right to such information under law or the Rules of Practice.

Yours very truly,

COMPANY,

Per: [Senior Officer]

The companies that filed acknowledgments of that kind are the following:

Anglo-Gibraltar Group
The Canadian Surety Company
Commercial Union Assurance Group
The Continental Insurance Company
Davies & Readley General Insurance Adjusters Inc.
The Dominion of Canada General Insurance Company
Economical Mutual Insurance Company

Employers Insurance of Wausau
The General Accident Assurance Company of Canada
Guardian insurance Company of Canada
The Halifax Insurance Company
The Home Insurance Company
INA Insurance Company of Canada
Independent Insurance Managers Limited
The Insurance Company of Ireland Limited
Morden & Helwig Limited
Phoenix of Canada
Royal Insurance Company of Canada
Sovereign General Insurance Company
Sun Alliance Insurance
Travelers Indemnity Company of Canada
Underwriters Adjustment Bureau Ltd.
United States Fidelity and Guaranty Company
Zurich Insurance Company

Other liability insurance companies made a similar acknowledgment through properly authorized employees who gave evidence at our hearings. They were:

Adamson's Insurance Adjusters Limited
Allstate Insurance Company of Canada
A. I. MacFarlane and Associates Limited
Bennett & Seaman Insurance Adjusters Inc.
Canadian General Insurance Company
The Co-operators
Eaton/Bay Insurance Company
Federal Insurance Company
Fireman's Fund Insurance Company, previously known as Shaw and Begg Gore Mutual Insurance Company
The Hartford
Markel Service Canada Ltd.
Pilot Insurance Company
Reliance Insurance Company
State Farm Mutual Automobile Insurance Company
The Wawanesa Mutual Insurance Company

As I have pointed out, liability insurance companies have agreed that they would not gather confidential health information from physicians, their employees or hospital employees without the written consent of patients. But this change in behaviour does not make redundant the recommendation that unauthorized communication with health-care providers be prohibited. Earlier, I expressed concern that the enhanced sensitivity to the threat to privacy may only be temporary. The need for a practical sanction will continue. If the conduct complained of is categorized as an offence against or under a provincial

statute, the period from the date of the commission of the act within which prosecution must be commenced is six months. But experience shows that, in the vast majority of cases, the person whose privacy is invaded learns of the invasion, if at all, well after the six months period. This makes resort to the Provincial Court largely illusory. In any event, that recourse ought not to be exhaustive of the rights of the person whose privacy was invaded. Professor Sandra Rodgers-Magnet, in the study which appears as an appendix to this report, has reviewed the civil rights of action which are or may be available to a patient in connection with the unauthorized or negligent release of his or her information. She has concluded that the existing remedies are inadequate. I agree with her.

Professor Rodgers-Magnet concluded that private litigation has two serious shortcomings. First, in the great majority of cases, the subject of an unwarranted and unauthorized disclosure is unlikely to know about the disclosure. Second, even if the subject learns about the disclosure, the measure of damages may well be so low that a civil action would not make economic sense. Nevertheless, I have reached the conclusion that the law should permit patients to commence an action for damages for the unauthorized, unjustified disclosure of their health information to third persons or for the inducing of such a disclosure.

These drawbacks of private litigation may be overcome by creating a right of action without the need to prove actual damage. Damages should be presumed in a significant amount, say \$10,000.00. The creation of a statutory cause of action would surely act as a deterrent. Those who might contemplate releasing or attempting to obtain health information without authorization and in unjustified circumstances should have to weigh the risk of judgment in this sum against the value of the information. Moreover, it would justify the patient in resorting to law. Finally, and perhaps most important, a statutory right of action would be a significant symbol of the value our society attaches to the right of privacy.

Recommendation:

13. That a statutory right be created permitting a patient whose health information has been disclosed without his or her authorization, to maintain a civil action for the greater of his or her actual damages or \$10,000.00 against:

(a) any health-care provider or other person under an obligation to keep

health information about the patient confidential, who unjustifiably discloses his or her health information to a third person; and

- (b) any person who induced anyone under an obligation to keep health information about a patient confidential, unjustifiably to disclose his or her health information.*

The Lawyers

Lawyers who are retained by persons who have suffered personal injuries and who wish to assert a claim against the persons who caused the injuries will, of course, have their clients' authorization to obtain their confidential health information. It is probably unnecessary to say that those lawyers need not resort to private investigators to obtain this confidential health information.

Insurance companies have an obligation to provide a defence for those whom they insure. This often means that they have an obligation to retain a lawyer to act on behalf of the insured. Of course, not all claims lead to litigation since many are settled at an early stage and not every claim results in the hiring of an investigator. The evidence before me indicated that investigation reports were obtained in approximately five per cent of all bodily injury claims. In the year 1977, there were 115,019 bodily injury claims handled by the members of the Insurance Bureau of Canada and investigation reports were requested in 6,140 of them. There is no doubt that a high percentage of the cases in which investigation reports were obtained were cases which eventually would be put into the hands of lawyers retained by insurance companies to represent the individuals insured. Insurers are sophisticated in the personal injury field and normally retain experienced, competent counsel who traditionally have been among the leaders of the Bar in Ontario. It was therefore exceedingly disturbing and distressing to me that the evidence revealed only one lawyer retained by an insurance company who had advised his client about the danger and impropriety inherent in the receipt of investigation reports containing medical information obtained without patient authorization.

Our investigation disclosed 25 lawyers, who, through private investigators, had sought or received confidential medical information without patient authorization. These lawyers may be divided into two groups:

1. those who ordered investigations using shorthand terms such as "background investigation", "activities check" and who repeatedly received investigation reports

containing confidential health information obtained without authorization and, as a result, ought at some point to have realized that to order an investigation report using such a shorthand designation was equivalent to expressly asking the investigator to obtain or to attempt to obtain confidential health information; and

2. those who expressly directed investigators to obtain confidential health information from persons and institutions having an obligation to keep that information confidential.

Throughout the hearings I heard many witnesses testify that they were unaware of the precise statutory provisions requiring physicians, for example, to keep health information about their patients confidential. Other witnesses testified that they were even unaware of a general obligation on the part of physicians to keep information about their patients confidential. Whatever the law may say, as a matter of fact, ignorance of the law on the part of the non-lawyers may be understandable and even excusable. As I have said, however, insurance companies usually retain experienced and very competent lawyers. Certainly, those who appeared before me fit into that category. It cannot be said that lawyers, and in particular those lawyers who were before me, were ignorant of the statutory obligations of confidentiality imposed upon physicians, hospital employees, OHIP employees and others in the health field. That these solicitors had actual knowledge of these obligations must be beyond question. Nevertheless, they failed to use their analytical skills, which they have in abundance, and continued to follow inherited practices, about which I shall have more to say later. In their behaviour they were slaves to precedent. In short, they failed to ask themselves the fundamental question whether it was proper to retain investigators to carry on in this fashion.

Mr. Strosberg was prepared to call all of the lawyers to testify and to explore their conduct. Most of them retained Kenneth Howie, Q.C., who carried on discussions with Mr. Strosberg with the aim of arriving at an agreed statement of facts and thus eliminate the need for an exhaustive examination of every lawyer's conduct on a case by case basis. This procedure was not a concession to these individuals and Mr. Howie because they were lawyers. Rather it was consistent with the practice followed by Mr. Strosberg on my instructions in his dealings with everyone who appeared at our hearings. The aim of the hearings was to determine if confidential health information had been sought or received, and, if so, by whom, whether the

instructions were given in circumstances in which the person giving them knew or ought to have known that such activities were wrong, the manner in which the information has been obtained and precisely what information had been obtained. If a witness were prepared to admit that he had engaged in this kind of conduct, knew or ought to have known at the relevant time that it was improper, undertook to discontinue it, and to co-operate with our inquiry in the future, if required, it would become unnecessary to engage in a clause-by-clause analysis of the investigation reports which had to be put in evidence in any event. The discussions proved fruitful. The acknowledgment that follows was made by Mr. Howie on behalf of the following lawyers (H.B. Campbell later joining the group by indicating his concurrence): Barry D. Brown, Q.C., E. Lyle Brown, Terrence J. Collier, Sheldon L. Drebin, John J. Fireman, Jesse T. Glass, Q.C., Cameron C.R. Godden, Douglas W. Goudie, Q.C., R. Bruce Lawson, Q.C., Paul A. Lee, Q.C., Robert C. Lee, Keith Lee-Whiting, Rudolph Lobl, the firm of Lyons, Arbus, Glenn A. MacPherson, William R. McMurtry, Q.C., Joseph W. O'Brien, Q.C., Claude M. Pensa, Q.C., Douglas H. Proudfoot, Q.C., Bert Raphael, Q.C., William P. Rogers, Q.C., James A. Sawers, Q.C., John C. Wilkins.

1. Hospitals and their employees and doctors and their employees have an obligation to keep the contents of health records of patients confidential ("the principle of confidentiality") and this was and is a subsisting and recognized principle.
2. The solicitors knew or ought to have known that the principle of confidentiality subsisted and ought to have recognized and accepted same.
3. For many years it has been a practice among the members of the legal profession and their staffs engaged in personal injury litigation to instruct investigators to obtain, and in consequence, to receive investigation reports which would contain, on occasion, amongst others, information from hospitals, hospital employees, doctors, doctors' employees, without the consent of the patient and therefore these solicitors ought to have known that such instructions were likely to result in

the receipt of investigation reports containing, on occasion, information from hospitals and hospital employees, doctors, and doctors' employees, obtained without the consent of the patient.

4. Some solicitors, on occasion, specifically instructed investigators to attempt to obtain medical information from hospitals, hospital employees, doctors, and doctors' employees, without authorization.
5. These instructions under the current state of the law cannot be justified.
6. The practice described had its roots in what was a very restricted system of production and discovery.
7. Recent changes in the Evidence Act and the Rules of Practice consequent thereon, widely expanded the scope of discovery available and it is conceded by the solicitors that there was no fresh look taken at the long standing practice in the light of their significance or these significant changes and that the practice cannot be justified.
8. As a matter of principle, on the current state of the law, solicitors recognize that hospitals, hospital employees, doctors and doctors' employees have an obligation to keep the contents of health records of their patients confidential. On behalf of these solicitors, Mr. Howie assured me that they would not seek to obtain such information without authorization, subject to the existing right granted by legislation and the Rules of Practice and that if such information is tendered, they will actively discourage the obtaining of such information on the part of investigators or others.

Although these admissions and the co-operation shown by the lawyers whose names I have given led to a substantial saving in time and effort during the course of our hearings, I believe that it is necessary to review some of the more blatant examples of the conduct that gave rise to these admissions.

Jesse T. Glass, Q.C., practises law in Toronto. Four investigation reports in which he requested an investigator to obtain confidential health information were filed in evidence. On October 28, 1978, Mr. Glass wrote to Kieran Patrick McCarthy, the principal of Quest Investigation Ltd., and advised him that he had been retained to defend an action arising out of a motor vehicle collision on December 16, 1974, and that the claimant had alleged injury to both thumbs. After providing background information, Mr. Glass gave Mr. McCarthy the following instructions:

We do not particularly require an activities check on this woman, but what we would like you to do is to look into her medical background in order to determine whether she has ever received any medical treatment or attention prior to the date of the accident relating to her hands, or generally for arthritic problems. She has been under the care of her family physician, Dr. H, of the

Medical Group, and under the care of an orthopaedic surgeon, Dr. Z, who is on staff at the Etobicoke General Hospital. If you have access to hospital and/or OHIP records, this might give us some insight into her medical background....

On December 6, 1976, Mr. McCarthy wrote the following letter to Mr. Glass:

In accordance with your written instructions of October 28, 1976, we have conducted enquiries into the background of , hereinafter referred to as the subject.

Unfortunately, her medical files have been transferred through three different doctors due to former general practitioners entering speciality fields and some continuity has, as a result, been lost.

There does not appear to have been any prior treatment for an arthritic condition of the

hands although we developed some information that indicates she presently has arthritic condition not related to the hands only.

The x-rays taken in November, 1975, diagnose an arthritic condition in her spine and the other x-rays taken of her left and right knees, right hip and femur seem to support a possible complaint of an arthritic nature. It is speculation of course, but they seem to have been looking for it and found it in her back, so we can only presume she was complaining of it.

On March 29th, of this year, her thumbs were given the all clear but arthritis was found in the back of the hands.

We attempted to press our enquiries in respect of a specific or otherwise, arthritic condition or the existence of treatment for an arthritic condition predating the accident but due to the multiple handling of the files by so many doctors, this information could not be confirmed or refuted...

The investigation report sent with this letter read as follows:

QUEST INVESTIGATION REPORT

MEDICAL INFORMATION DEVELOPED:

Enquiries of the family physician Dr. H, revealed that he has transferred the handling of this patient, and subsequently her medical files, to a Dr. B as of July 25, 1975.

Similarly, it was determined that Dr. B has since turned his general practice over to a Dr. D in order that Dr. B could enter a speciality field of medicine.

The Dr. D referred to has his office located at [address], [telephone number], (listed still to Dr. B).

The last visit the Subject made to Dr. D's office was on March 11, 1976 at which time,

she complained of having problems with her back and legs, complaining of pain.

Prior to that visit, and in November of 1975, she had attended Etobicoke General Hospital for x-rays, having been referred there by Dr. B.

The x-rays taken of her spine show osteoarthritic changes (degenerative). She has also had x-rays taken of her chest, right and left knee, right hip and femur.

Dr. H originally treated the Subject at the time of the accident and his report states in part, that the Subject had been driving, had stopped for a crosswalk and was struck by another vehicle. At the time of the collision, the Subject was holding onto the steering wheel and recalls falling forward but not striking her head. She complained of pain in both thumbs. Examinations at the time revealed tenderness, x-rays were taken but they revealed no bony injury.

The Subject was seen by Dr. Z, an Orthopaedic Specialist at Etobicoke General Hospital.

Dr. Z saw the Subject December 3rd and 16th, 1974 and on March 29, 1976.

Diagnosis at the time of the accident was a ligamentous strain and soft tissue contusions to both thumbs. X-rays were taken at this time as well and neither hand showed a bony injury.

The Subject's last recorded visit to Dr. Z was March 29, 1976. At this time, there was no pain associated with the thumbs although there was some stiffness in the backs of the hands.

X-rays taken in March showed minor degenerative osteoarthritic changes.

BUREAU NOTE:

- #1 Dr. Z sent a report to the Subject's insurance company on January 15, 1976. He has also sent reports to Mr. Offman, the Subject's lawyer, on March 3, 1975 and on May 5, 1976.
- #2 The Client's office was contacted and the date of accident was verified as being December 2, 1974 and not December 16, 1974 as originally given.

There is no evidence that Mr. McCarthy attempted to obtain information from OHIP but it is clear that Mr. Glass expressly instructed Mr. McCarthy to attempt to obtain OHIP information and information from the hospitals without the claimant's authorization. The instructions were improper and Mr. Glass must have known that he was acting improperly in counselling Mr. McCarthy to induce an OHIP employee to breach the general obligation of secrecy imposed upon the employee by section 44(1) of The Health Insurance Act, 1972, S.O. 1972, chapter 91, as amended by S.O. 1974, chapter 60, section 9.

Glenn MacPherson carries on the practice of law in Toronto. He was retained by an insurer whose insured was involved in a motor vehicle collision on November 4, 1968. In September, 1973, he retained an investigation agency, Canadian Consumer Retail Association, or C.C.R., who employed an investigator, A.J. White. He gave oral instructions to Mr. White, and, as the investigation proceeded, Mr. White contacted Mr. MacPherson's office to advise him of its progress. By letter dated September 21, 1973, Mr. White reported to Mr. MacPherson in summary form. In concluding, the letter said:

This will confirm our several telephone conversations and discussions on the case with Mr. MacPherson, up to the present time. As requested, we are submitting this report to you in its present form, along with the documents we have obtained in this investigation, in order that they may be available for your action before September 24, 1973.

By letter dated September 27, 1973, Mr. White reported in detail. The claimant had, for a time, been a private investigator and Mr. MacPherson was interested, in the claimant's work history, amongst other things. The report was 20 pages long. The salient portions read as follows:

Following this investigator's discussion of the case with Mr. MacPherson in the latter's office, investigation was commenced to cover specifically the claimant's activities from the date of the accident, namely November 4th, 1968, to the present time, with special emphasis placed on income and employment during this period. As we understand it, you have information to the effect that the claimant, had presented a claim to the Allstate Insurance Company during the year 1970 for injuries he alleged were received in an auto accident during that year. You indicated that Mr. _____ had received a settlement from the Allstate Insurance Company, part of which was based on _____'s claim for loss of income during the period from the date of the accident to a date not specified during that period.

Information that you supplied indicated that Mr. _____ had produced as evidence of his employment and income in connection with the Allstate claim a bill of sale from a Mr. _____ of [address], Downsview. This sale was apparently for some \$6,000.00 for a trailer which Mr. _____ claims to have constructed himself. In some way, the sale was done through a company called _____ Limited on [address] in _____. _____ had also indicated that he was a principal in a company called _____ of [address] in Toronto, and that he also had a connection with a company called _____ of no known address. Also he had indicated he was employed as a security guard with _____ Ltd., Toronto for a brief period in 1971.

We first checked with the registration department of the Ontario Provincial Police which is responsible for the licencing and policing of security guard and investigation companies in this Province.

A confidential source contacted there supplied the following information from Mr. _____'s record.

Mr. [redacted] was born in Holland on February 20th, 1911 in the city of Amsterdam. He came to Canada in August 1959.

Although our source there indicated that the information regarding employment came from his application to [company name], the O.P.P. appeared to have some more details regarding his employment than those contained on the application form to [company name], a copy of which is enclosed. You will note on the [redacted]'s application form that [redacted] lists his employment from September 1959 through to November 1968.

There are gaps in the period of employment listed on the [company] application form, and presumably these were filled in in the course of the O.P.P. investigation of for his licence to be employed as a Security Guard. They do not, however, show his employment further back than 1962.

We draw your attention to the fact that on the [company], application form [redacted] lists his first employment in Canada as lasting until August 1961. However, his next employer, he indicates, was not until May of 1963, this being the [company name] on [redacted] Highway in [redacted]. There is no explanation for this gap of almost two years. Again, there is a gap in employment as indicated on his [company] application form from June 1967 to January 1968. You will note that [redacted] claims to have been employed at [company name] on [address] in Mississauga up to November 1968 and his reason for leaving there, he has listed as car accident. We draw your attention however, to page 1 of his [company] application form where there is a question which asks if the applicant has ever had a serious illness or serious accident. [redacted] did not answer this question nor did he supply details as requested in the followup question to that.

The O.P.P. source supplied an employer not listed on [redacted]'s application form and this

is a company which they show as [company name] on [address]. According to the O.P.P. indicated or was verified as having been employed with this company during the period between October 1964 to April 1965. He gave as his reason for leaving this company the fact that the plant had closed. This company as you will note is not mentioned by himself who filled out and signed the application form.

According to the O.P.P. records, was employed with [company name] in or between September 1962 to September 1964 and this conflicts with the information given by himself on his own application form.

Also, according to the O.P.P. records, claimant worked for the Government of Canada at the Department of on [address] in Toronto during the period of between December 1966 and June 1967. Again there appears to be a discrepancy here between the O.P.P. records and 's own statement. The O.P.P. records also show that he was employed with [company name], [address], Toronto between April 1965 and October 1966. His reason for the change from the Department job, was that the job was finished.

was granted a licence to be employed as a security guard with the [company name] and was employed with them from September 10th, 1971 to December 14th, 1971. His reason for leaving [company name] was listed only as "Resigned".

There is no employer listed according to the O.P.P. between the period 1968 and September 1971 when applied for the job with [company name]. There is nothing on the O.P.P. records to show any explanation for this gap in his employment, but neither is there any comment to the effect that he was disabled during this period and unable to work.

We checked local reference books and the current telephone book for any listing for a company called [redacted] and at [address] in [redacted], or in fact at any address, but find no listing for any company by this trade style. We also checked the current City Directory for 1973 and it shows no such address as [address] in New Toronto.

The same is also true of [redacted].

There is nothing to indicate any violations of licence requirements as covered under the act governing the licencing of investigators or security guards. The O.P.P. has had no occasion since [redacted] left [company name] to conduct any investigations on the claimant or to be interested in his present employment.

From this they assume that he is not working in the security field, and has not done so since 1971 when he resigned from [company name].

[redacted]

In the meantime, we requested a police check on the claimant and we also requested a confidential source to make a check of welfare records to see what information might be available to confirm the above information that he may have been receiving welfare prior to 1971. To this point, we have not received any replies to either our police or welfare requests.

[redacted]

Confidential Source

Toronto, Ontario

September 20th, 1973

Our source has access to confidential OHIP records and with the claimant's OHIP number, he obtained a print out of benefits paid to [redacted] and/or his family under this particular number. The OHIP number in question was [redacted]. Our source found an irregularity in this OHIP number as it appeared to be the

number of the claimant's wife. There was some confusion to begin with as the OHIP number seemed to be in the name of a man, but we later unscrambled this and satisfied ourselves that the record in fact was under the name of born in November of 1909, and the wife of your claimant, or .

Our source indicated that the OHIP records had been "purged" as of the date September 1972. For this reason, the record of benefits or treatment under this particular OHIP number prior to this date were not immediately available. Our source did offer to make a search for the record prior to this date, but this may take several days to obtain. We will forward this information on to you as soon as we receive it.

From what information that was available, it would seem that the claimant's wife, has been getting frequent and regular treatment in the form of doctor's visits, diagnostic and laboratory tests and neurological examinations. The coding on this particular OHIP record would seem to indicate that testing was concentrated in the area of diagnosing or treating a urological disorder. This would cover such things as disorder of the kidneys, renal malfunctions, diseases or disorders of the urinary tract, calcification as in the case of kidney stones, etc. The exact condition is not specified because of the general coding of records of this type. The record is reduced to a film record, hence the use of codes for the disorder, treatment or diagnostic procedure.

With regard to the claimant, , the record shows that he had x-rays taken on December 29th, 1972 and the coding indicates only that the x-rays were done by a clinic or general group called Diagnostic Radiology. This may be the name of a clinic or it may be only the general coding for the type of service performed. On the same date, December 29th, 1972, there is a record

that the claimant, , had an office visit with his general practitioner, who is identified as Dr. J. The fact that he had a doctor's visit and x-rays on the same date might indicate that he was complaining of flu or bronchial disorders although this is not specified by the code.

On February 19th, 1973, had a general assessment examination, and this was in the order of a routine annual physical.

On April 18th, 1973, he had treatment by an orthopedic specialist and the coding for his condition would indicate an arthritic or gout condition.

This is the extent of information available from his record covering treatments and benefits eligible under 's OHIP coverage.

As mentioned above, our source will check further into this record to see what treatments or ailments are recorded prior to September 1972, specifically to cover the period back to 1968. Source will also attempt to determine if this is a self-paid coverage or if he is covered under a group and if so, he will identify the employer. It is possible that the claimant's wife may have had coverage if she was ever employed. He will also attempt to find out if this particular OHIP coverage is in any way connected with Welfare or any other public assistance agency. As indicated, we anticipate a delay of several days, but we will get you the information as soon as possible.

We must caution you about the use of this information so that its source is not identified. We understand that our last conversation with Mr. MacPherson on September 20th, 1973 confirmed that this will not present any problems to you.

• • • •

ADDENDUM

Further to our several telephone conversations with your office, this is to confirm that we have finally received word on our inquiries through the Police Department, the Metro Toronto Welfare Department and OHIP.

Claimant does not have a police record.

Welfare sources report no record of any payments ever paid to your claimant. This does not exclude the possibility that he may be receiving benefits under the Provincial Welfare system. We are, unfortunately, unable to confirm or obtain any information through the Provincial Welfare scheme.

OHIP reports back that they have checked all the way back to the commencement of the current OHIP plan, which was April 1, 1972. This search produced only two entries. One on August 24th, 1972 which was an office visit with an orthopedic specialist, apparently for a diagnostic evaluation. The other entry is for November 23rd, 1972 and this was for a lab test listed only under the general heading of micro-biology. This would be something in the order of a routine urine test. No other entries on his OHIP schedule.

A further check under the membership records of OHIP revealed that Mr. is a Pay Direct subscriber.

Further checking revealed, however, that the claimant is receiving full premium assistance through OHIP. This means that he has satisfied OHIP that he has limited or no income. We are checking further to establish whether or not is admitting any income.

This information is to be obtained through a different department at OHIP and we are advised there may be a delay of several days. We will continue to follow up and

will advise you as soon as we have some information.

On October 12, 1973, Mr. White followed up with a report which read as follows:

Further to our report to your attention dated September 21st, 1973, and further to our telephone conversation with Miss Saracini of your office of last week, we enclose herewith additional information received from one of our confidential sources.

As you may recall, we had requested information through one of our sources with access to confidential OHIP records, specifically with regard to checking eligibility for OHIP coverage without having to pay premiums.

Our source reports that the only information available on this subject indicates that Mr. [redacted] applied for full family coverage under the OHIP provision which allows residents of Ontario to have free OHIP coverage based on a low income qualification. In Mr. [redacted]'s application to the OHIP Commission, he declared an income for the year of 1972 of \$2,982.13. He was asked to provide an estimate of his 1973 income but said that he could not. Our source suggests that the income figure of \$2,982.13 is most likely an income after taxable deductions. This would be suggested by the exact amount given by him rather than an estimate rounded out in even thousands. Source here pointed out that a total income before taxes of up to \$3,400.00 is allowed and any such application showing this income would be eligible for the free OHIP benefits.

Mr. [redacted]'s application form signed in January 1973 gave his employment as "Unemployed". His occupation he listed as "former carpenter".

Our source here explained again that no proof of income is required from these applicants so that the figure given for

income is not substantiated by T-4 slips or any other documentation. The whole system is based on the honour system and source admits that they have many people abusing this privilege. As a carpenter, he could have sizable tax deductions for tools, material, work clothes, etc. No facts or figures, however, are available on this. Mr. [redacted] indicated that his wife was not employed....

From these reports I conclude that Mr. MacPherson knew that Mr. White was attempting to obtain confidential health information from OHIP. I believe, moreover, that Mr. MacPherson fully expected Mr. White to attempt to obtain this information. If he had disapproved of Mr. White's behaviour, Mr. MacPherson would have asked him to refrain from it. It is clear that he had ample time and opportunity to do so and that he had notice of his intended course of action. He did not lift a finger.

On May 16, 1974, a motor vehicle collision took place in which a claimant was injured. The injuries were caused by a person insured by State Farm Mutual Automobile Insurance Company, or State Farm. Paul A. Lee, Q.C., of Toronto was retained by State Farm to defend the action brought by the claimant. In due course, by letter dated February 11, 1974, Mr. Lee requested a private investigator to undertake an investigation of the claimant and to come to his office to read his file. On February 15, 1974, the investigator attended at Mr. Lee's office and received oral instructions which he reduced to writing in the following form:

CLIENT REQUIRES:

1. Photographs of her active, picking up the child or some heavy weights.
2. Photographs of her walking down stairs.
3. Background.
4. Check out Centennial College.
5. Medical, Dr. S (fam. Dr.) and Dr. H (Ortho).

The investigator carried out his investigation on March 31, 1977, and reported to Mr. Lee. The covering letter read as follows:

Dear Sir:

As instructed, we have conducted investigations in the above captioned matter, and our

report, together with several photographs taken of the subject, is enclosed. Additional photographs will be forwarded as soon as they have been processed.

Briefly, inquiries at the various schools where subject has worked would indicate that there has been considerable change in the subject's personality since the accident, and she has definitely had considerable time off.

On the other hand the inquiries of medical sources would seem to indicate that subject's problems are more psychological than physical.

It would seem a possibility that the subject was suffering from some problems with her nerves prior to the accident and we inquired about this at all the schools, but could not get a confirmation of this. We would however refer you to the remarks of Dr. G who states that the subject did have problems with her nerves prior to the accident.

We have also conducted some observations on the subject, during which time she appeared to be in normal physical condition.

We are holding our file with this writing, pending further instructions, and our account to date is enclosed.

Yours very truly,

Part of the report enclosed with the letter follows.

MEDICAL INFORMATION - Monday, March 1st, 1977

Dr. G, [address]

Dr. G advises that he is no longer the subject's family physician, as of November 1976, at which time he commenced specializing in allergies and sent all his records to a Dr. Ga, [address].

Dr. G states that he sees the subject regularly to administer allergy shots. In February 1976 he saw the subject for a myelogram and discogram at North York Hospital and the results did not indicate much if anything wrong with subject. He referred the subject to Dr. A who is an orthopaedic surgeon because he could not understand why she was not recovering faster. He mentioned that he thought the subject's problems might be psychological. However, Dr. A apparently thought there was something to subject's complaints and he believes that Dr. A referred her to a pain clinic at Western Hospital.

Dr. G also added that the subject had problems with her nerves prior to the accident but he wouldn't or couldn't elaborate because his files are now all with Dr. Ga. Dr. G states that he has not had much to do with the subject concerning her accident but he does recall that at the time she had considerable pain. He adds also that the pain may have adversely affected her nerves. Subject's allergy shots are for asthma, and he states that it has been under control for some time.

WESTERN HOSPITAL, PAIN CLINIC, Friday, March 4th, 1976

Investigator interviews staff at out-patient clinic and is advised that the pain clinic is for individuals experiencing pain for which no physical causes can be found. It is believed to be run by a group of doctors headed Dr. V.

DR. V

This source is a neurosurgeon at [address], and he refused to provide any details concerning the subject, however he did outline the purpose of the pain clinic. He did confirm that the subject had been referred to the clinic by Dr. A, and that she is not currently attending the clinic.

Dr. V explained that the pain clinic is run by a group of specialists from many fields.

The persons suffering from chronic pain are referred here. The pain may originate from organic or psychological reasons. The doctor outlined an example where a patient would be treated at the clinic and then referred to a specialist in a specific field. In the case of the subject, the only specialists who assisted Dr. V with the case was a Dr. S, a psychiatrist.

Dr. V termed the pain clinic as the last resort for persons suffering from pain. He explained that people who complain of chronic pain have to be believed and even if the pain is as a result of psychological reasons it is real to the patients.

DR. ABELL, 1333 Sheppard Ave. East

This source was interviewed and refused to provide any information. The sign on his door indicates that he is an orthopaedic surgeon, and also that his office is the North York Pain Clinic.

DR. Ga, [address]

This doctor was interviewed and he confirmed that he assumed the records of Dr. G. Dr. Ga has a file on the subject and appears to be acting as her family physician. He refused to provide any information without a written release, and mentioned that the Ontario Medical Association has sent a newsletter around warning doctors against releasing medical information.

The evidence satisfies me that Mr. Lee expected that the investigator would approach Dr. S and Dr. H despite the fact that he knew that these physicians had an obligation to keep health information about their patients confidential.

In October, 1970, a claimant was shopping in an appliance store in Timmins. A sales person moved an article holding a loose table leg causing the leg to fall and strike the claimant on the head. The claimant commenced an action for damages for personal injuries. The appliance store and sales person were insured by Maryland Casualty Company whose claims manager was William K. Miller. Mr. Miller assigned the defence of this action to John J. Fireman, a lawyer in Toronto. In due course, the action proceeded through examinations for discovery and

Mr. Fireman reported to Mr. Miller that in his opinion the defendants were liable for the damages suffered by the claimant and that the thrust of the defence ought to be an attempt to prove that the injuries complained of by the claimant were not caused or contributed to by the falling table leg. In his written report to Mr. Miller, dated January 15, 1974, Mr. Fireman went on to say:

Obviously, investigation is absolutely necessary into those two Companies to determine whether they have any previous records of this woman's health and attendance. She was absolutely emphatic on the issue of her prior health which she maintains was absolutely perfect. She claimed that she never even had so much as a minor headache. Naturally her entire claim is based upon headaches as a result of our accident.

She has left herself wide open to be contradicted if indeed there are contradictions to be found....

More specifically, she denies any illness with regard to her spine or any accidents either industrial or motor vehicle before his accident.

She claims that she was only in the hospital once for pleurisy, but aside from that, nothing except for child birth...

Mr. Miller, understandably, interpreted this to be a recommendation to retain a private investigator to carry out an investigation. His handwritten note on his copy of the report reads, "Check hospital re: health". He retained Centurion Investigation Ltd. to send a bilingual investigator to Timmins. In due course, Mr. Miller delivered Centurion Investigation Ltd.'s report to Mr. Fireman who provided an extensive written criticism of it by letter dated July 8, 1974, addressed to Mr. Miller. The letter contained these comments:

I note that I had not forwarded to you any of my comments on the Centurion Investigation.

I find it unfortunate that the very item that we were concerned with is not covered which of course is the question of precisely

when following the accident did this woman start to complain of neck problems.

It does not appear that any efforts were made to approach the physicians that attended her or their nurses, nor does it appear that the housekeeper was ever questioned closely with regard to how shortly after the accident she recalls the claimant complaining of neck problems...

The criticism that Centurion Investigation Ltd. did not approach the physicians or the nurses is particularly remarkable when one realizes that Mr. Fireman was then dealing with the claimant's lawyer Rino Braganolo who, at the examination for discovery, had voluntarily provided Mr. Fireman with medical reports from the attending physicians. As a result of the criticism, Mr. Fireman was instructed by Mr. Miller to direct the investigation. He met Mr. McCarthy and an investigator employed by Centurion Investigation Ltd. on July 30, 1974. Mr. McCarthy prepared a memorandum for his file which is of sufficient importance that I set it out in full:

Pat McCarthy met with Jack Fireman at 11:00 A.M. Tuesday, July 30, 1974, and was at the time accompanied by Mr. Nick Galanos.

Mr. Fireman's comments relate to additional investigative requirements in respect to some of the points brought out by our initial investigation.

They are in the main contained in the photocopied letter from him to Bill Miller and dated July 8, 1974, that has been appended to the file by Mr. McCarthy.

Mr. McCarthy pointed out to Mr. Fireman that it was a pity we had not been provided with copies of the medical reports prior to our commencement of this investigation as the obvious discrepancies therein indicate the areas of most importance. Copies were furnished and are attached to the file.

What he needs to know is:

- 1) Do any of the first three doctors consulted, C, S, and M, have any notation to any neck complaint?
- 2) Who is Dr. Co? What are his comments, treatments, etc.
- 3) Clarify the number of days per week (housekeeper) worked.
- 4) Does she remember any neck problems? Do not lead in these questions.
- 5) If she does mention neck problems, has she been checked?
- 6) Pertinent to the list on page #3 of report of April 3 - What days did she have off? Were they all together etc.?
- 7) What do other teachers and colleagues have to say as to previous health?
- 8) Was there any other letters of excuse for time off that might indicate previous accidents or illness?
- 9) Search of County Court records, etc. for writs re previous accidents or claims.
- 10) Check local hospital records for previous treatment.
- 11) Re Mr. dismissal. Is this public knowledge? Was it reported in local newspapers? Any scandal, etc.

Mr. Fireman was most emphatic that every lead, every possibility and every exigency be followed up on as this case will most definitely go to trial in Cochrane in the fall.

Mr. McCarthy has supplied Mr. Fireman with the original statements as requested.

Most important is to pressure as to his statements re previous neck problems and to follow up on same.

Copy of letter of July 8, 1974 to in
this regard is also attached.

On August 26, 1974, Mr. Daniel McGarry, of Centurion Investigation Ltd. reported to Mr. Miller the results of the further investigations which had been carried out on Mr. Fireman's instructions.

His letter, a copy of which was forwarded to Mr. Fireman along with the report, confirmed that the investigation had been carried out on the express instructions of Mr. Fireman. It said:

... As per the instructions received in the letter from your solicitors, Lee, Dyson, dated July 16, 1974, from Jack J. Fireman, and from information received from him in a meeting on Tuesday, July 30, 1974, at approximately 11:00 a.m., we have conducted further investigations regarding the above, and submit our report to date...

The report contained the express instructions given by Mr. Fireman, in almost the same language as that set out in the above recital of Mr. McCarthy's memorandum and then continued as follows:

TUESDAY, JULY 30, 1974

Meeting held with Solicitor, Jack J. Fireman, at 199 Richmond Street West, offices of Lee, Dyson, Barristers and Solicitors, re: instructions of investigation to be carried out.

• • • •

MONDAY, AUGUST 12, 1974

• • • •

The investigator then contacts Dr. Stephen Cohen, 208 Third Avenue, Timmins, Ontario and requests information from him in relation to the Claimant and is advised that he will give out no information without a signed authorization from the Claimant.

• • • •

The investigator then speaks with Dr. John Sullivan, 303 Fifth Avenue, Timmins, Ontario, and requests information in relation to the Claimant and is given the same short, curt reply, that no information will be given out without the written, signed authorization of the Claimant.

• • • •

The investigator then contacts Dr. C, [address], Timmins, Ontario, speaks with him in relation to the Claimant and is advised by the Doctor that he would give out no further information without the signed, written authorization of the Claimant, who is his patient.

• • • •

The investigator then contacts Dr. M, [address], Timmins, Ontario.

Dr. M advised the investigator he only saw the Claimant once.

Then Dr. M was handed a copy of his letter dated December 4, 1970, and stated, after reading same over, that there was no indication of any neck or back injury as a result of the accident, September 25, 1970.

He reports that the Claimant did not mention any previous neck or back injury.

• • • •

The investigator then contacts Mr. at [address], Timmins, Ontario, [Employer of Claimant] further to information already obtained.

Mr. reports that to find out what days Subject had off would require them to go through their records month by month looking for Subject's name.

Claims he doesn't have the staff. Would only do so if he were served with a subpoena.

Information previously given re days off taken from a separate card, and only total days off shown.

Mr. [redacted] did advise the investigator that he has two (2) letters in the Claimant's file from doctors. He showed these to the investigator, who noted that the letters were as follows:

The first one was dated February 17, 1969.

It states:

This will certify that I have advised this woman to remain away from work for an indefinite period of time for health reasons.

Signed: Dr. C

The second letter, dated April 21, 1972, states:

Anterior cervical discotomy and fusion on March 8, 1972.

Medically unable to return to work before approximately August 1, 1972.

Signed: Dr. D

.

The investigator then made inquiries at St. Mary's General Hospital, and attempted to speak with [redacted] who is the Administrator of the hospital, to find she was away on holidays, and then made several inquiries, only to be advised by the records department that they would give out no information in relation to the Claimant, without written authorization from the doctors involved.

Although Centurion Investigation Ltd. obtained little health information, this sequence of events clearly demonstrates that Mr. Fireman improperly directed an investigation, the aim of which was to obtain confidential health information without consent, at a time when he was dealing with a fellow lawyer who had provided him with substantial health information. Mr. Fireman must have known this conduct was improper.

John C. Wilkins carries on the practice of law in Toronto. I was made aware of four cases in which Mr. Wilkins requested investigators to obtain confidential health information. I need not review the circumstances of each of these cases in detail. Two examples will do. By letter dated February 12, 1976, acting on behalf of The Western Assurance Company, Mr. Wilkins gave the following instructions to Kenneth Maslen, a private investigator:

What we would like in your investigation is some information as to this woman's activities from the date of the accident up to the present time, including occupational activities and activities at home. If it is possible to get any further confidential medical information to determine whether or not this woman has received any treatment in the year 1974 it would be of assistance. The reason I write this is because there are some medical reports for 1973 and some medical reports for 1975 there appears to be a year in between where nothing was done. This seems strange to us and we were wondering if there is any prospect the woman has had some other accident or some aggravation to her condition, which is not related to our accident at all.

Mr. Maslen was unsuccessful in obtaining any such information in this case.

On February 20, 1975, on behalf of the Royal Insurance Group, Mr. Wilkins instructed Centurion Investigation Ltd. to carry out an investigation and to attempt to obtain confidential health information without the authorization of a claimant. The instructions to Centurion Investigation Ltd. were in this language:

Respecting this above styled matter, you have conducted investigations into Mr.

in the past and I refer you to your file number 1929-1.

We would be pleased if you could conduct some further investigations into this woman - first of all with respect to observations and surveillance to see what her capabilities are as she is alleging a continuing nagging back discomfort and arthritic condition arising out of the accident.

In addition, we would be pleased if you would approach whatever confidential sources you may have with Chrysler Canada Limited in order to determine what this lady's absentee record was prior to this accident on May 13, 1972. I believe that the company has required the filing of various medical reports or medical statements surrounding why this woman took certain time off work and on April 23rd, demonstrating that she was off work March 12th, 13th and 14th, in 1973, which would seem to show that she was off work the day before the accident.

I am wondering if there is any past record which they might keep demonstrating any back condition prior to the accident. There is also a group accident insurance which might have kept some record and medical reports respecting payments which they would have made on her behalf.

If you can possibly note any past medical diagnosis and also note any medical diagnosis since the accident as I see there is reference in a letter of July 8th from the Company to lumbago and degenerative disc disease. I do not know if any one would let you have copies of the doctor's letters filed in this respect but it would certainly be of a great deal of help to know what was contained in those letters in order to attempt to bind the Plaintiff and the doctors to that diagnosis made at that time for that purpose. I say this because the Plaintiff is making a claim for wage loss of \$4,500.00 and I understand that it is increasing as time goes by.

We would be pleased to receive an interim report as you progress in this investigation. Some of your material and information will certainly already be contained in your earlier data which you have in your file.

Acting on these instructions, Centurion Investigation Ltd. provided Mr. Wilkins with a report which, in part, read as follows:

MONDAY, MARCH 24th, 1975

Investigator learned from the confidential source, that the Claimant, has been employed since September 1962.

Medical Records indicate that she was off work during 1967, suffering from pain in her sacral spine area.

Medical records did not show the exact dates that she was off work, or the cause.

Medical records, in 1969, showed the Claimant being off work as follows:

August 4, 1969 to August 13, 1969,

Reason: The flue

October, 1969 to November 1969,

Reason: lumbar and sacral disease.

June 2, 1970 to June 19, 1970,

Reason: strain to left foot.

July 12, 1970 to August 24, 1970,

Reason: cholecystectomy.

January 22, 1971 to April 19, 1971,

Reason: surgery to heel.

June 7, 1971 to July 26, 1971,

Reason: osteochondritis.

May 12, 1972 to May 29, 1972,

Reason: Motor vehicle accident causing injuries to head and knee

April 19, 1973 to May 3, 1973,

Reason: bronchitis.

July 27, 1973 to August 20, 1973,

Reason: lumbago.

November 20, 1973 to January 14, 1974,
Reason: degenerative disc
disease.

April 14, 1974 to June 24, 1974,
Reason: degenerative disc
disease.

Investigator was advised that the Claimant
returned to work, June 24, 1974.

Investigator was also advised that the
Claimant received benefits under the group
insurance plan, Aetna Life Insurance. The
following is the amount of money received by
the Claimant.

May 12, 1972: \$189.00
For July 27, 1973: \$176.00
For November 20, 1973: \$840.00
For April 14, 1974: \$1,120.00

Investigator was advised that the Claimant's
rate of pay, based on 40 hours per week is
as follows:

May 1972 - \$4.48 per hour plus \$.04 per hour
cost of living.
July 1973 - \$4.61 per hour plus \$.30 per
hour cost of living.
November 1973 - \$5.12 per hour plus \$.05 per
hour cost of living.
April 1974 - \$5.12 per hour plus \$.25 per
hour cost of living.

Investigator was also advised a couple of
the doctor's names who treated the Claimant
for her disabilities during November of
1973, and April of 1974.

The doctors are Dr. L and Dr. F.

Investigator thanked the confidential source
for the information.

TUESDAY, MARCH 25th, 1975

Investigator, establishing that the Claimant
was at home, proceeded to her residence and
set up re observations.

THURSDAY, MARCH 27th, 1975 to SATURDAY,
APRIL 5, 1975

During this time the investigator made numerous discreet inquiries in regards to the Claimant's medical background.

Investigator subsequently contacted Dr. L's office and discreetly learned that the Claimant's only visit was on April 18th, 1973, at which time she was complaining of soreness in her back.

She advised the Doctor that she had been suffering from arthritis, the Doctor prescribed Valium (5mg).

Doctor advised the investigator that this was the only time he had seen the Claimant for a consultation.

Investigator made further inquiries and was advised to contact Dr. F's office at the Clinic.

Investigator subsequently contacted the Clinic and discreetly learned that Dr. F wrote a letter to Dr. L on November 28th, 1973 regarding the Claimant's history. The letter goes as follows:

It was dated November 28th, 1973, to Dr. L, re Mrs. .

"I reviewed your 36-year-old Chrysler punch Operator and, as you know, at age 24 she had carcinoma of the cervix treated with radiation and cobalt. From that period, about 8 years ago she developed low back pain and lost some time from work because of it more recently. The most disturbing feature is anterior thigh pain, pain in the area of the patella and upper tibia. This does not bother her at night, nor does it bother her when she coughs, but heavy movement apparently does give her discomfort. Physical examination shows her to be 5'1", 155 lbs.,

with an adequate range of motion. There is some restriction but it is not marked. Straight leg raising is virtually normal. Reflexes show an absent ankle jerk on the left. No other great abnormality. Her sensation is normal. She does have some minimal patellofemoral crepitus; but this is not marked. X-rays of her lumbar spine show that there is a great deal of degenerative disc disease and a huge spur at the 4-5 level, both anterior and posterior, indicating that she has marked severe degenerative changes here. The one problem is diagnosing this, other than obvious degenerative disc disease, is that because of the radiation she may have some hip involvement which may cause this thigh pain, or it could be from the back. I have asked for hip X-rays to be taken. I have told her that her major problem is her gross obesity and, if she loses weight, she will be markedly improved. I have asked her to be instructed with some physiotherapy. If she is not improved with this, then I feel the only other alternative is to admit her to hospital for further investigation, i.e. milogram. One would have to consider doing spinal fusion but I would not attempt this until she has lost at least 30 pounds, i.e. weighing 120 pounds. She will check with you in a few weeks and hopefully she will be markedly improved. Thanks for asking me to see her."

Investigator was advised that the Claimant was only seen by Dr. F, on this occasion.

Investigator made further inquiries and was advised that Dr. F had written a letter to Dr. M who is not connected with the hospital or clinic, but has his own practice at [address], Oshawa, Ontario.

Investigator was advised that there was another letter from Dr. R, a gynecologist in regards to the Claimant.

Investigator was advised that there were x-rays taken of the Claimant's left foot, lumbar sacral spine, and both hips, but there was no notation of the date in regards to her x-rays.

Investigator made further inquiries and it was learned that Dr. W is now attending to Dr. M's patients.

The investigator contacted Dr. W's office and discreetly learned that the Claimant has been a patient since 1964.

Investigator was advised that in 1968, the Claimant's lumbar spine was examined resulting in indications of lumbar disc disease.

Investigator made further inquiries, and was advised, that this examination took place in September of 1968.

Investigator was advised that in 1969 the Claimant attended the Doctor's office complaining of back pain.

Investigator was advised that in 1970 there is a letter to Dr. G, in regards to the Claimant's complaining of pain to her back and right sacroiliac.

Investigator was advised that the letter goes as follows:

I still could not find any evidence of root compression which would lead me to consider her to be a surgical candidate. She is still considerably overweight, and I think she should make a real effort in weight reduction, and then be fitted with a strong lumbosacral support.

Investigator made further inquiries and was advised that Dr. W's office had the majority

of the correspondence and letters prior to 1970, had either been destroyed or filed away, when Dr. W took over Dr. M's patients.

Investigator was advised that in May of 1972, Dr. M wrote a letter in relation to the Claimant's medical background to Thompson & Rogers. The Doctor's secretary read portions of the letter to the investigator, goes as follows:

She demonstrated full range of motion in the neck. No tenderness in the neck. Right forehead was swollen and tender with a very small abrasion over area. The periorbital area on the right was swollen and bluish. The eye was not injured. There was a bruise the size of a quarter under the right knee. Tenderness over the thigh on the right. This caused some discomfort with walking. She was seen again on May 23rd, 1972, and the entire periorbital area was now yellow. This extended across the frontal area into the scalp. Middle ear appeared normal though the patient complained of pain in ear. Full range of motion of neck. Complained of pain on full extension. The patient had point tenderness on right C5 and C6. Right thigh tender. Small bruising seen on lateral portion. Prognosis was good.

This is what he assessed on all her motor vehicle accident injuries.

Investigator made further inquiries and was advised of another letter dated April 1973, which goes as follows:

In January 1973 I examined Mrs. who at this time was complaining of pain in both elbows. In March 1973, she complained of pains in her hands, knee, shoulder and chest. On March 26th, 1973, she had pain in

her dorsal spine, pain in the left shoulder and pain in the upper left quadrant and left groin. She went to physiotherapy for these things.

That mentions a little bit about the dorsal spine.

Investigator made further inquiries in regards to x-rays taken of the Claimant prior to 1972.

Investigator discreetly learned that the Claimant had a GI series, a skull, a left foot and lumbar spine x-rays, done prior to 1972.

Investigator was advised that the spine x-ray was in 1970, this x-ray showed the bones to be of normal density and texture, sacroiliac joints are normal. There is well marked degenerative disc disease at L4-5 with early degenerative changes at L5-S1 and L2-3, the latter being of questionable significance. The pedicles laminae and transverse processes appear intact.

Investigator made further inquiries and was advised that the cervical spine x-ray was taken in November 1972, which showed it to be normal.

Investigator made further inquiries but was unable to disclose any further information in regards to the Claimant's medical background.

There can be no doubt that Mr. Wilkins expressly instructed investigators to seek confidential health information without the authorization of the claimants. He must have known that these instructions were improper.

A motor vehicle collision took place on August 3, 1976, in Metropolitan Toronto, causing injuries to a claimant. H.B. Campbell of Toronto was retained to defend the action commenced by the claimant as a result of this collision. By letter dated January 11, 1978, Mr. Campbell expressly instructed Monarch Protection Services Limited to carry out an investigation on his

behalf and to attempt to obtain confidential medical information. The instructions were as follows:

Would you please contact the Plaintiff's employer and find out for what period of time he was off work, whether there was any vacation during that period of time, his observations or employees' observations with respect to his working ability; in other words, to find out whether he is pushing this a bit far. I would also like to know what his income loss would be for the period which he was off work.

He has seen Dr. D. [address], Rexdale, [telephone number]. It would be helpful if you could find out the nature of his injuries and the doctor's prognosis with respect to those injuries as well as any treatment.

I would appreciate this information at your earliest convenience.

The investigator was unsuccessful in his attempt to obtain health information from the physician without authorization because the claimant had instructed the physician to refer any requests for information to his solicitor. However, Mr. Campbell expressly instructed the investigator to attempt to obtain confidential health information without authorization when he surely knew the physician had an obligation to keep this information confidential. He must also have known that to give instructions of that kind was improper.

William P. Rogers, Q.C., practises law in Toronto. We found six investigation reports all prepared by Equifax Services Ltd. in respect of which Mr. Rogers had either instructed Equifax to seek health information without the patient's consent or in respect of which that company had provided information of that kind to Mr. Rogers. Mr. Rogers usually gave instructions in writing. His letters of instructions requested Equifax Services Ltd. to determine "what disabilities, if any she may have had together with any previous records on accidents or illnesses claimed", or "I would appreciate it if you would check out the background of these people for previous accidents, claims and for illnesses or sicknesses, as well as employment earning times lost from work, if any", or "Perhaps you can determine from the school whether the girl has had any previous psychological problems of this nature prior to the accident", or

"I would appreciate it if you would check on this man's claims background for sickness, accident or ill health as well as his earnings, lost time from work and what, if any benefits were available to him." These instructions were, not unnaturally, interpreted as instructions to seek confidential health information without authorization and were, I am sure, so intended.

I shall provide one detailed example of the type of information sought and received. On April 16, 1975, a motor vehicle collision took place in which a child of 14 years and her mother were injured. Mr. Rogers was retained to defend the action brought by these claimants. By letter, dated November 15, 1977, and addressed to Equifax Services Ltd., Mr. Rogers requested that an investigation be carried out and instructed Equifax Services Ltd. to "determine from the school whether the girl has had any previous psychological problems of this nature prior to the accident."

As Equifax proceeded with its investigation, its investigator Herbert Brereton kept in touch with Mr. Roger's law clerk for whose action Mr. Rogers has quite properly accepted responsibility. The clerk supplied the investigator with the names of physicians and specialists who attended both claimants and, after receiving this information, Mr. Brereton concentrated his efforts on the injuries that the claimants were said to have received in a subsequent motor vehicle accident. Through his law clerk, Mr. Rogers knew that Mr. Brereton would be seeking confidential health information from the physicians and hospitals without the claimants' authorization. On December 7, 1977, Equifax Services Ltd. sent the following information to Mr. Rogers:

Morning Star Secondary School,
3131 Morning Star Dr.,
Mississauga, Ontario.
Dec. 2, 1977.

This High School has been in operation since Friday, Nov. 25, 1977 at this address. Morning Star had been previously operating out of Westwood Secondary School down the road at [address], Mississauga. [REDACTED] is a Grade 11 student here presently, has been since school commencement date Sept. 7, 1977. Present Grade 11 Home Room Teacher identified as Mr. [REDACTED]. [REDACTED] has taken over [REDACTED] class now for the past two weeks. Her former Home Room Teacher was Mr. Bruce Savage. [REDACTED]'s Phy-Ed teacher identified

as Miss Lamson. Source confirmed as Mar. 7, 1961 residence [address], Mississauga. Parents identified as Mr. and Mrs. .

is in a four year Arts and Science Course here. During month of Sept. 1977 there were a total of 18 school days. Out of those 18 school days, was absent 6 days and late for 2 days. The latter was due to physio-therapy treatment she was and still is now taking at the Etobicoke General Hospital.

For the month of October 1977, there was a total of 22 school days. Out of those 20 school days, was late 10 days and absent for 4 days. The former again due to physio-therapy treatment at the Etobicoke General Hospital. Might add that there is no indication on record concerning reason for the absent days in September and October 1977 as noted.

For month of November 1977, there was a total of 21 school days. Out of those days, was late for 16 days re physio-therapy and absent 2 1/2 days. Again no reason noted for her days absent.

For dates of Dec. 1 and 2, 1977, has been late both days for physio-therapy.

We questioned why 's physio-therapy visits increased in October and November versus September, finding that she was involved in a subsequent motor vehicle accident Wednesday or Thursday, Nov. 23/24, 1977. She was driving a vehicle at the time. Passenger in the car identified as her girlfriend, Miss , Malton, Ontario. Could obtain no further information from this source. Was referred at this time to Guidance Head, Mr. Dave Binns. Binns proved somewhat unco-operative. Would advise no further information on at this school.

We next handled through Westwood Secondary School, 3545 Morning Star Dr., Mississauga. Conversation with Mrs. Peck, secretary and

Head of Guidance, Mr. McNeice could only determine that was attending Grade 11 classes at this school plus associating with Morning Star Secondary School since Sept. 7, 1977. Before this she was naturally attending through Westwood Secondary in Grade 10 classes. Since would have been attending at Westwood Secondary in Grade 10 classes on or around April 16, 1975, we questioned concerning loss of time from school and other pertinent facts. Were told that no information could be released without approval of subject or her parents.

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Handling next conducted through the Etobicoke General Hospital, 101 Humber College Blvd., Etobicoke. Through source known to investigator, limited information was obtained on subjects as follows:

did have x-rays at this hospital April 16, 1975 while an Emergency Patient. Attended in Emergency by Dr. . Her OHIP number on file as . Address confirmed as Mississauga. Date of birth confirmed .

Concerning we note that she had x-rays at this hospital May 5, 1974, they being skull, chest and humerus order by Dr. P, [address], Weston, Ontario, [telephone number]. No x-rays concerning noted on or after loss April 16, 1975.

We made further check through the hospital for Sick Children, 555 University Ave., and the Queensway General Hospital, 150 Sherway Dr., Etobicoke concerning x-rays if any on Miss or mother , either following or prior to loss April 16, 1975 - negative results.

• • • •

Based on information provided us through Morning Star Secondary School, investigator next rehandled through the Etobicoke General

Hospital, 101 Humber College Blvd., speaking with Mrs. , Physio-Therapy Dept. Find no record of one Miss attending for physio-therapy here either now or in the past.

Next handled through Etobicoke Medical Centre, 400 The East Mall, Etobicoke, through their Physio-Therapy Dept. speaking with Mrs. J. Again no treatment here for one Miss re physio-therapy either now or in the past.

Through this location we also spoke with Mrs. Ha, secretary to Dr. H, [telephone number]. H as you know was the Emergency physician in attendance with the Etobicoke General Hospital April 16, 1975. Mrs. Ha had no chart information or otherwise concerning nor indication that Helman followed her up as an office patient subsequently. Nevertheless she would check out this for us and recontact investigator at her earliest convenience.

NOTE:

Were next in conversation with Mr. William Rutherford of your company advising him of our handling to date. Were to handle this investigation further as discussed. Mr. Rutherford supplied us with names of physicians/specialists who have attended both and to date since the accident. Wished that we concentrate our efforts on the subsequent MVA involving as developed. Wished that we also handle concerning 's treatment at the Etobicoke General Hospital May 5, 1974 as it appears that treatment was concerning a previous MVA involving her. Supplied us with the Auto Carrier on date of loss along with policy number. Also wished that we handle investigation further concerning up-to-date physio treatment on . Granted us additional expenditure of \$100 for completion of report at this time.

Next handled through office of Dr. Thor Popadyne, 1570 Kipline Ave., Suite 3, Weston, Ontario, 244-8733. On speaking with the secretary and this physician personally, both during morning and afternoon, Dec. 5, 1977, could obtain no information without benefit of signed authorization.

Next handled with Mr. Malcolm Herd, Claims Dept. Norwich Union Fire Insurance Society Ltd., 60 Yonge St., Toronto, Ontario, 362-2961. Policy number 8AT3412 no longer in force through this company. Policy according to records expired July 9, 1977, renewal date being the previous year July 9, 1976. Agent listed Jim Heath Insurance Agency. Heath apparently sold his business to C. K. Johnson and Associates Ltd., Willowdale, Ont., early 1977. Mr. Herd pulled the above stated Policy number for us and noted three separate losses in 1975 i.e.: Jan. 11, Jan. 13, and April 11, 1975. No further information on same determined. The Claim Files if available would be destroyed. The same holding true for the Policy itself. Mr. Herd had no recollection concerning the loss of April 16, 1975. Appears that the loss was never reported to Norwich Union. No additional pertinent facts to advise us.

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Office, Dr. Ralph N. Wright,
G.P. and Family Physician,
715 Scarlett Rd.,
Weston, Ontario.
241-2761
Dec. 4, 1977.

Both and were initial office patients here April 18, 1975 following the accident. We note that born 1964 also attended that day concerning minor whiplash injuries. Neuro-surgeon, Dr. P admitted to the Sick Children's Hospital for tests Oct. 14, 1975. Her hospital stay was a duration of some two weeks. Both and were attended by neurologist Dr. S

at the Etobicoke General Hospital. attending his office July 31, 1975, Sept. 1975. was last in the office here Nov. 2, 1977. That visit not related to the accident in any way. She was suffering from a cold/flu at the time.

is at the moment attending therapy sessions in Brampton as arranged recently by psychiatrist, Dr. C. Also confirmed fact that had tests done at the Queensway General Hospital. Dr. Wright of course has received follow up letters from all the above named specialists concerned in the case. The last letter dated Feb. 15, 1977 is from office of psychiatrist Dr. C, [address], Brampton, Ontario. Dr. C's summary of her at that time is as indicated, the patient had up to that point been suffering from a dystrophic reaction which had occurred shortly after the accident and may have well formed a psychological block aggravating the problem since then.

C mentioned then he had applied hypnosis to her but this proved unsuccessful. Further conversation with and her mother, the patient seemed well motivated because of the obvious limitation she was suffering at the time. He described her as a quiet spoken nervous young lady. She had very little grasp in her right hand with marked reduced sensation in the third, fourth and fifth digit from the base of the digit to the tip on all aspects. He indicated then that she had marked reduced grasp and some atrophy in the dorsum of the hand. The patient at that time had complained of tenderness in the shoulder extending from the base of the neck into the superior aspect of the scapula and out through the shoulder. That area was tender to pressure and some reduction in muscle strength was noted.

Mrs. we confirmed did have a laminectomy L4-5 performed by Orthopedic surgeon Dr. N at the Peel Memorial Hospital in December 1976. According to available information it appears that Dr. N orthopedically reassessed her in the office after

that time. Dr. Wright has essentially attended in the office here since that period until now for problems non-associated with any accident. She was last into the office Nov. 2, 1977 with daughter for diet pills. According to source the laminectomy performed by Dr. N was minor surgery. She seems to have made a normal, lasting and complete recovery now. We did of course question concerning treatment at the Etobicoke General Hospital May 5, 1974 by Dr. P as noted. Source had recalled that

was indeed involved in a motor vehicle accident on or around that date causing whiplash type and back injury. Was unable to advise us one way or the other whether Dr. Wright had attended her subsequently in the office. It appears that her back injury sustained in the accident April 16, 1975 may well have been an aggravated condition brought on by this previous accident May 5, 1974.

We find no reference to the recent MVA involving nor indication Dr. Wright has attended her in the office since. Suggested we contact Dr. C in that regard. Was her opinion that Dr. C was to date still attending as an office patient. She may have made mention to him of that most recent accident concerning their health history revealed no prior accidents or injuries other than noted to

Physiotherapy Department,
Humber Memorial Hospital,
200 Church St.,
Weston, Ontario,
249-8111
Dec., 5/77.
Contact by phone
3rd attempt made dates specified,
provided the following information.

Miss we confirmed did attend here for physiotherapy treatments between period May 5, 1975 - June 12, 1975 (total of 14 visits). Referring physician identified as Orthopedic Surgeon, Dr. Z, [address],

Weston, Ontario, [telephone number]. Physiotherapy was regards to injury of the right wrist. We note on regards to 's visit here, May 14, 1975, it was noted that she was at that time receiving a treatment to her right shoulder for 15 minutes followed by resistive exercises. On her final visit June 12, 1975, under physiotherapist Mrs. D, we note the patient was given wax to manipulate within her right hand for fifteen minutes. There were no complaints at that time concerning right shoulder pain or discomfort. She received active exercises for the right upper limb of the arm as well as ball throwing and wrist gripping, wax and ball squeezing. The right wrist also received resistive exercises that day. It was noted as of June 12, 1975, the patient was to start occupational therapy and the physiotherapy was to be discontinued awaiting on the outcome of the occupational therapy treatment to follow. There was no further record of occupational or other type of therapy following June 12, 1975 available. Source was unable to comment in this regard. Referred us to the orthopedic surgeon, Z on [street] for additional assistance.

We did speak with Miss D, secretary to Orthopedic Surgeon, Dr. Z, [address, telephone number], this day. She could find no record of treatment by Dr. Z to .

We might also inform you of a phone call received from Miss. Lamson, 's phys-ed teacher through Morning Star Secondary School afternoon, December 5, 1977. Advises she does not preside over phys-ed classes. Is not her phys-ed teacher, would find out who is and have that individual re-contact investigator at his/her earliest convenience.

We might inform you of additional inquiries on an indirect basis through the Etobicoke General Hospital, evening, December 5, 1977. As well as confirming that was attended in emergency by Dr. P, May 5, 1974.

It was determined this was most certainly for a motor vehicle accident occurring on or around that date. She had sustained injury to one of her arms that day. The family physician both confirmed and identified as Dr. Ralph N. Wright, 715 Scarlett Road, Weston. No additional relevant facts.

Peel Memorial Hospital,
20 Lynch Street,
Brampton, Ont.,
Dec., 6/77.

Mrs. , date of birth confirmed September 28, 1929, OHIP # confirmed under husband given as , [address], Mississauga, was admitted to this hospital through the emergency department, November 17, 1976. Hospital number identified as . Attending physician, Dr. N, [address]. No discharge date available.

Admitted to hospital for an acute herniated lumbar disc. There was indication that did undergo a laminectomy L4-5 while here. No additional facts obtained further in that regard. While an in-patient, had a mylogram performed November 18, 1977. An x-ray involving a disc case injection was ordered by Newall November 19, 1977 and that specialist ordered a discogram November 22, 1977. Unfortunately, results of those x-rays could not be obtained. No in/out patient care for one located.

We did also handle through the physiotherapy department Peel Memorial Hospital at this time. Spoke with Mrs. C-therapy head. While confirming Miss is presently on a programme through this hospital as ordered by Dr. C, she declined to divulge any information on the matter without benefit of signed authorization.

We were next in conversation with Mrs. L, medical secretary, orthopedic surgeon, Dr. N, [address], South Brampton, [telephone number]. did receive post op care in this office following discharge from the Peel Memorial Hospital. We confirmed Dr. N

did perform a laminectomy L4-5. We confirmed her admittance date as November 17, 1976. Would not advise us her discharge date. Moreover her post op visits while available were not released. She is no longer a patient of Dr. N. Was discharged from care some time ago. Past this point, no additional assistance, given us without benefit of signed authorization.

We were next in conversation with secretary to Psychiatrist Dr. C, [address], Brampton, Ontario, morning and afternoon December 6, 1977. While confirming that [redacted] is still attending with this psychiatrist presently, we were unable to obtain details of any assessment dates past February 15, 1977. We were in conversation with the psychiatrist we found him totally un-cooperative.

We did receive word back from Mrs. H, Secretary to Dr. Arthur H, afternoon December 6, 1977. H did not follow up either [redacted] or [redacted] further to his emergency treatment of them April 16, 1975, at the Etobicoke General Hospital. No additional relevant information to what we have already established.

Mr. L. Rogers,
Vice Principal
Morning Star Secondary School,
3131 Morning Star Drive,
Mississauga, Ontario
December 7th, 1977.

Advises he was asked to speak with this investigator by Miss Lamson interviewed the previous day in this report. Confirmed all information obtained on [redacted] through initial handling at Morning Star Secondary above in report. Added the following information:

[redacted] will be taking five subjects to complete her Grade 11 credits. The present semester involves [redacted] taking Geography, Theatre Arts and English. For her next semester beginning January 1978 she will be taking only two subjects, Phys. Ed and light

skills. As you can see, [] is not attending Phys. Ed classes this present semester. Her marks this year are average we learn. Mr. Rogers himself is not aware of any problems concerning []'s right hand nor her ability to work effectively in class. Neither her present home room teacher Mr. [] or her former teacher Mr. Bruce Savage have made any comment to Mr. Rogers in this regard. Phys. Ed teacher next semester will be Miss Lamson we learned. When [] attended Grade 10 classes at Westwood Secondary during the 1976 - 1977 year she was taking physical education classes under Miss Sue Robertson. That teacher still works out of Westwood Secondary. [] requires twenty-seven school credits to achieve her Grade 12 diploma. Mr. Rogers feels that [] having achieved this will join the work force and not further her education. Mr. Rogers was aware of []'s most recent accident with [friend] as developed. He confirmed that [] lost considerable time from school since commencement in September 1977 for therapy colds/flue etc. Past this point could add no further relevant information. Did not feel that Mr. Savage or [home room teacher] could be of additional assistance to us. Suggested we speak with Miss Robertson further concerning her prior knowledge of [] in Grade 10 at Westwood Secondary.

We did through some difficulty next obtain interview with Miss Sue Robertson, Phys. Ed teacher, Westwood Secondary School, 3545 Morning Star Drive, Mississauga, Ontario 676-1191.

Miss Robertson did confirm that [] attended her Phys. Ed classes in Grade 10. Miss Robertson was unaware of the accident April 16th, 1975. She could personally not recall observing noting on record, or hearing from principal/vice-principals concerned at this school concerning any curtailment of activity for [] in Grade 10 for Phys. Ed. The girls in [] class

took up track and field, volley ball, badminton, tennis, dancing and swimming.

while in Grade 10 participated in all the above activities. To her knowledge also took Phys. Ed classes in Grade 9. She would check with the Public Nurse, Mrs. Morris, who would be in on Friday, December 9th, 1977 regarding whether had a Phys. Ed restriction imposed following the accident and other such relevant information which concerns same.

Would recontact this investigator on or shortly after Monday, December 12th, 1977.

• • • •

WOMAN SUBJECT:

and are mother and daughter respectively. They reside at captioned address with other members of the as developed in body of report. holds a full time job through as a clerk-typist. Would also hold duties of a full-time working housewife. Would receive assistance from other members of the family in this regard including .

is a Grade 11 student presently attending at Morning Star Secondary School, Mississauga. It seems that does come home for lunch school and will make her own lunch accordingly. This is confirmed through information obtained in report. Neither nor hold interest outside the home in social clubs or sporting functions.

SPECIAL ATTENTION:

This case was handled paying special attention to information as you wished covered in your letter dated November 15th, 1977 and through further conversation with your Mr. William Rutherford December 5th, 1977.

We hope to obtain details concerning any previous psychological problems re from the Health Nurse, Mrs. Morris through

further conversation with Miss Sue Robertson
on or after Monday, December 12th, 1977.

In my discussion of Equifax Services Ltd., I refer to the incident about which Mrs. Jane Wright testified. She was the source of information referred to in this report as it relates to the office of Dr. Ralph Wright. I also point out that I heard, as well, from Mr. Brereton, the Equifax investigator who prepared this report. Mrs. Wright said that she had received a telephone call from a person who represented that he was Dr. Burton, that she could not recall whether or not this caller mentioned OHIP but, because of what he said, she had assumed that he was from OHIP. During the course of this call it was necessary for Mrs. Wright to obtain the claimant's file and, as she was searching for the file, Dr. Wright asked her why she was searching for this file. She replied that it was Dr. Burton from OHIP who wanted to know the dates of the claimant's visits. Mr. Brereton in his evidence denied that he represented himself as Dr. Burton. I prefer Mrs. Wright's evidence and I conclude that he did in fact represent that he was Dr. Burton from OHIP.

Mr. Rogers did not know that Mr. Brereton would so misrepresent himself. However, there is no doubt that Mr. Rogers, having expressly instructed Equifax to obtain confidential health information without authorization must have expected that some trick or ruse would be resorted to to obtain the required information. He must be taken to know that the giving of instructions of that kind was improper.

William A. Jenkins, Q.C., practises law in London, Ontario. He was retained to defend an action brought as a result injuries suffered by a pedestrian when hit by a motor vehicle on May 13, 1977. He received an investigation report prepared by Cortlaw Services Ltd. dated May 25, 1977, which disclosed that the claimant had been hospitalized in Victoria Hospital. The relevant portion of this report follows:

VICTORIA HOSPITAL,
SOUTH ST.,
LONDON, ONTARIO

On May 19, 1977 the Out-Patient Department stated that she was admitted to Room 818 West.

I interviewed at the Nurses' Station 818 West, and she said that the claimant was under the care of Dr. B, and she is in to have a series of tests done on her back. As yet the tests have not been ordered by the

doctors involved, and it is normal for the patients to take a long weekend bedrest to see if that will help before tests are ordered. (It is noted that the weekend of the 21st to 23rd of May inclusive is a long weekend). Miss D said that Dr. B will not order any type of tests until May 24, 1977; we should re-contact herself or possibly the head nurse Mrs. K after that date.

After reviewing this report Mr. Jenkins gave the following written instructions to Cortlaw Services Ltd. on July 6, 1977:

In your report of May 25th you indicated that you were going to check with Victoria Hospital to ascertain the result of the tests taken by Mrs. . We would appreciate receiving your further report as soon as possible.

On receipt of these instructions Cortlaw Services Ltd. did not attempt to obtain information from Victoria Hospital but, instead, attempted to obtain health information from the offices of two physicians. It is clear, however, that Mr. Jenkins specifically instructed Cortlaw Services Ltd. to obtain health information without authorization from Victoria Hospital after he had received the investigation report which contained confidential health information obtained without authorization. Mr. Jenkins's conduct was improper. His counsel, Angus L. McKenzie, Q.C., who appeared on his behalf at our hearings in London, agreed that Mr. Jenkins ought not to have requested such information.

The 25 lawyers whose names we discovered in the files we examined were not the only lawyers in Ontario who engaged in the practice of retaining investigators to obtain confidential health information without patient authorization. Our investigation revealed 1,597 investigation reports prepared by investigators in which confidential health information had been obtained without that authorization. Although this is a statistically significant sampling and an evidentiary base from which I may reasonably draw conclusions about the conduct of the investigation industry, insurance industry and legal profession, our investigation was not exhaustive. We did not attempt to discover every case in which confidential health information had been sought or received. The Insurance Bureau of Canada, commonly known as the I.B.C., is the marketing representative of the insurance industry in Canada and represents private insurance companies who wrote in excess of \$4 billion premiums in

1977. This premium dollar figure represents 95 per cent of the total general insurance premiums written by private insurance companies in Canada in the year 1977. In response to my request, the I.B.C. canvassed its members and reported to me through its counsel, R.F. Wilson, Q.C., that the practices referred to in Mr. Howie's statement were "...generally followed throughout the Province by lawyers involved in insurance litigation." Seven lawyers actively practising in the insurance field came forward voluntarily, admitted that they carried on practices such as those described and subscribed to Mr. Howie's statement. They were Crawford M. MacIntyre, Brian J.E. Brock, W. Graham Dutton, Q.C., Robert Cram, James M. Regan, W. Thomas McGrenere, Q.C., and Joel Weslin. They did not have to reveal themselves. They did so voluntarily and as an act of public service. I commend them for their so doing.

Elsewhere in this report I have expressed an opinion against prosecuting persons who have acted improperly and even illegally. It is right that I should run the risk of repetition in relation to that issue as it relates to the behaviour of these 25 lawyers. Although there is no doubt that they have acted improperly, I recommend that no criminal prosecutions be undertaken. To single out this specific group would be unfair. It is, moreover, not possible to identify all the lawyers who have engaged in similar practices and because it is known that many have, it would be discriminatory to proceed against these whose activities came to my attention. The insurance industry, in effect, is the client of the lawyers practising at the defence bar so that the industry undertaking will act as a check upon the lawyers. The raised consciousness among, and the recognition of the problem of confidentiality by, members of the legal profession brought about by our hearings, persuades me that lawyers will no longer be involved in such activities. I have no doubt that our hearings have brought to a stop the practice of obtaining confidential health information without authorization. Because of the undertakings given, the publicity which these hearings have generated, and the identification of those named, similar practices will, I am confident, not begin again in the future.

Lawyers should, however, be expected to adhere to a higher standard of propriety than other persons. It is significant that during the hearings a witness made, and then withdrew, an allegation that I would not fully explore the involvement of the legal profession in the obtaining of confidential health information because, although I was prepared to expose others, I could be expected to protect lawyers who had been guilty of the same conduct. The fact that it was made may be evidence of a general attitude which, although indefensible, exists and

necessitates extreme diligence on the part of the legal profession to ensure that their actions are scrupulously proper.

The statement made by Mr. Howie was an unequivocal acknowledgment of the impropriety of the conduct described and an unequivocal undertaking to refrain from engaging in it. In my experience it is difficult to have any two lawyers agree to anything controversial. To obtain an agreement among 24 lawyers to a given statement is highly unusual and significant. This agreement would have been impossible without the efforts of Kenneth Howie, Q.C., Douglas Goudie, Q.C., Brian Wheatley, Q.C., W. Graham Dutton, Q.C., and Roger Radford, a vice-president of Royal Insurance Company of Canada, all of whom met with Mr. Strosberg and associate commission counsel, Carene Smith, to formulate this statement in the form which I have set out. I express my gratitude to these persons for their frankness, cooperation and efforts in causing lawyers with such diverse interests to come to an agreement which greatly assisted this inquiry.

One last question remains. Its answer is not easy. Why did such competent and reputable lawyers engage in the indefensible practice? To begin with, they probably did not direct their minds directly to what they were doing. No effort could have been made to reconcile the attempts to have persons bound by law to keep information confidential part with information the disclosure of which had not been authorized with what, they must have known, had they thought about it, the law required. More important is the statement found in Mr. Howie's acknowledgment. Civil procedure discovery provisions were once much more primitive than they have recently become. Lawyers learn their practice, as opposed to their theory, from practising lawyers. One generation teaches the next. The practices I have been discussing are old and originated with a generation of lawyers at a time when consciousness of the importance of privacy and confidentiality was not high and when discovery mechanisms were rudimentary and inadequate for modern needs. The learning generation of lawyers inherited the practice and never stopped to ask themselves why they were continuing it and why it was still necessary, given the disappearance of the factors that brought it about. The power of analysis that every good lawyer has was not used. Precedent, good or bad, is still too often the guide.

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